

**DEPARTMENTS OF LABOR, HEALTH AND
HUMAN SERVICES, AND EDUCATION, AND
RELATED AGENCIES APPROPRIATIONS FOR
FISCAL YEAR 2010**

TUESDAY, JUNE 9, 2009

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 2:30 p.m., in room SD-124, Dirksen Senate Office Building, Hon. Tom Harkin (chairman) presiding.

Present: Senators Harkin, Kohl, Pryor, Specter, Cochran, and Alexander.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF THE SECRETARY

STATEMENT OF HON. KATHLEEN SEBELIUS, SECRETARY

OPENING STATEMENT OF SENATOR TOM HARKIN

Senator HARKIN. The Subcommittee on Labor, Health and Human Services, Education, and related agencies will come to order.

Madam Secretary, I welcome you to your first hearing with this Appropriations subcommittee. You have a challenging job ahead of you, I believe the most challenging job, I think, in the Cabinet, but also I think the best job in the Cabinet.

Your responsibilities include not only comprehensive healthcare reform, preparing for a possible pandemic influenza, addressing costs of entitlements, but also biomedical research, substance abuse, drug safety, and quite a few others.

I certainly look forward to working with you in any way that I can. This hearing will focus of your discretionary budget, but I would just like to mention what we're doing on comprehensive healthcare reform.

I know that you feel very strongly that prevention in public health must be at the heart of any serious reform of the healthcare system and I commend you for your work in that area. I also believe that any reform of the healthcare system must address the injustice of people with severe disabilities, who are being forced to spend their lives in nursing homes because we do not provide the option of home-based services for the severely disabled. That's why I've introduced the Community Choice Act of 2009 (S. 683), which President Obama strongly supported during the campaign and

which he co-sponsored when he was here as a member of this subcommittee. So, I look forward to working with you on this issue.

Today, we want to talk about the fiscal year 2010 budget and also about the funding included in the Recovery Act of the stimulus that we passed. That bill included \$10 billion for the National Institutes of Health (NIH), \$1.1 billion for comparative effectiveness research, \$700 million for prevention activities and \$2 billion for discretionary health information technology activities, as well as funds for Head Start, child care, Community Services Block Grant, and health professions.

So, we will cover as much as we can. Again, we welcome you to the subcommittee. I will leave the record open for a statement by Senator Cochran and I would then recognize you, Madam Secretary, and your statement will be made a part of the record in its entirety.

HEALTHCARE WASTE AND HOSPITAL-ACQUIRED INFECTIONS

And, as a matter of introduction, Kathleen Sebelius became the 21st Secretary of the Department of Health and Human Services on April 29, 2009. In 2003, she was elected as Governor of Kansas. And I thank you for coming up to Iowa many times. I always enjoyed seeing you in Iowa and working with you. She served in that capacity until her appointment as Secretary.

Prior to her election as Governor, she served as the Kansas State Insurance Commissioner and is a graduate of Trinity, Washington University, and the University of Kansas.

Madam Secretary, Mr. Cochran.

Senator COCHRAN. Mr. Chairman, I am happy to join you in welcoming the Secretary to the hearing. Thank you very much.

Senator HARKIN. Thank you, Senator. I left the record open for your statement.

Madam Secretary, welcome. And please proceed as you so desire.

SUMMARY STATEMENT OF HON. KATHLEEN SEBELIUS

Secretary SEBELIUS. Well, thank you Chairman Harkin, Senator Cochran, and members of the subcommittee. I want to thank you for the invitation to come and discuss the 2010 budget.

HEALTHCARE REFORM

I want to first start by thanking you for your hard work and leadership on a whole variety of health issues. We certainly face great challenges in the country today and I look forward to working with you to tackle those challenges together. Healthcare reform is one of the issues I know that is front and center in the Senate and the House right now and I think that there is great agreement that we can't continue with the status quo. The President is committed to healthcare reform. I think we're seeing businesses and Government and families and providers come together to acknowledge that the crushing costs are influencing family's bottom-line, the competitiveness of our businesses, and we have to find a way to deliver higher quality healthcare for all Americans.

I do agree with you, Senator, that prevention and wellness are an essential component of that transformational health policy. And

some of those building blocks, as you say, have already been provided. But I look forward to being part of that discussion as it moves forward, in terms of healthcare reform.

Now, I think the budget we're considering today puts us on the path to healthcare reform and adheres to the principles outlined by the President, building on the investments in a 21st century healthcare system. The American Recovery and Reinvestment Act funded some priority areas, including making a substantial down-payment on healthcare reform.

There's a focus on fraud, which is costing taxpayers billions of dollars each year. And we intend to do more to crack down on individuals who currently cheat the system. So, the Attorney General and I, first time ever at a Cabinet level, announced an interagency effort to fight Medicare and Medicaid fraud through improved data sharing, real-time information that would be available, and increase the number of strike forces that have been successful in a couple of areas and we would like to see them increase their operations. And the budget includes some recommended increase to help Health and Human Services achieve our part of the bargain.

We also have initiatives in the budget to move toward a central goal of healthcare reform, improving the quality of care. The patient-centered research that is funded in this budget helps give doctors and patients access to better information and better treatments, helps empower consumers and providers. So we hope that, not only would we be looking at some cost-saving strategies, but improving the quality of healthcare for everyone.

HEALTHCARE DISPARITIES

The budget invests \$354 million in target activities to combat health disparities. Senators, I just came from a dialogue with close to 30 stakeholders representing various minority populations and communities who are very interested in working on closing the gap on quality of healthcare delivered across America. The gap that exists for higher income Americans versus lower income Americans and certainly the gap that we see persistent in ethnic minorities and low income and disadvantaged populations and that is a continued priority with the Department.

We have included more than \$1 billion in the Health Resources and Services Administration (HRSA) to support a wide range of programs dealing with the workforce issues. Clearly a critical component of healthcare reform is having enough providers to deliver the care to all Americans. So, the funding will enhance the number of nurses and doctors, the number of dentists and mental health professionals, and particularly also targets minority and low-income students to encourage more access to the medical profession. And an increased emphasis to make sure seniors get the care and treatment they need.

PANDEMIC FLU

And finally, the budget will support our work at the Department to protect public health and the safety of our citizens. As the chairman has recognized, we are not only dealing with an ongoing presentation of the H1N1 flu virus, but also the ongoing preparedness

and operations to respond to whatever outbreaks may strike next and threaten the health of the American people.

There's no question that the investments made in pandemic planning and preparation by this subcommittee and Congress over the years has allowed our Department to respond efficiently, but we need to continue those efforts and make sure that we are well-prepared. We don't know what the next depths of this virus might be when it comes back in the fall in this country or what will happen exactly this summer, when it presents itself in the Southern Hemisphere in conjunction with their flu season. So, the President has submitted a supplemental request to support the Federal response to the recent outbreak. So the funds, in addition to those provided in the 2010 budget, will allow our Department to continue to be the primary health agency responding to this outbreak and remain prepared to protect the American people.

So Mr. Chairman, the President is committed to a safer, healthier, and more prosperous America and we feel this budget will help achieve those goals, investing in reform, improving on the quality of care, and continuing to provide essential services that so many families depend on.

PREPARED STATEMENT

So, I look forward to taking your questions and those from other subcommittee members and, more importantly, to work with you on these important goals.

Senator HARKIN. Madam Secretary, thank you very much for your summation and, as I said, your full statement will be made a part of the record in its entirety.

[The statement follows:]

PREPARED STATEMENT OF KATHLEEN SEBELIUS

Chairman Harkin, Senator Cochran, and members of the subcommittee, thank you for the invitation to discuss the President's fiscal year 2010 budget for the Department of Health and Human Services (HHS).

In these times of economic uncertainty, we at HHS are even more cognizant of the healthcare needs of American citizens. It is during times like these that we must be especially mindful to answer the call as public servants to protect the health of the American people as well as ensure the availability of healthcare resources. At HHS, we are dedicated to the continued improvement and accessibility of healthcare in the United States and committed to providing essential human services that families depend on, particularly in times of economic crisis.

The HHS fiscal year 2010 budget reflects a dedication to focus resources in the areas of health reform, improving the quality and accessibility of healthcare, delivering human services to vulnerable populations, securing and promoting public health, investing in scientific research and development, and ensuring the successful implementation of the American Recovery and Reinvestment Act.

The President's fiscal year 2010 budget for HHS totals \$879 billion in outlays. The budget proposes \$78 billion in discretionary budget authority for fiscal year 2010, of which \$72 billion is within the jurisdiction of the Labor, Health and Human Services, Education, and related agencies Subcommittee.

Health Reform

I would like to begin my comments by addressing our efforts in the area of health reform.

One of the biggest drains on American family budgets and the performance of the economy is the high cost of healthcare. American families and small businesses are being crushed by sky-rocketing healthcare costs and they are losing the very choices they value most.

Health insurance premiums have doubled since 2000, rising four times faster than wage growth. This increase strains both families and the businesses that struggle

to sustain health benefits for their employees. At the same time, healthcare costs are consuming a rapidly growing share of Federal and State government budgets.

The United States spends more than \$2.2 trillion on healthcare each year, a number that represents about 16 percent of the total economy. Experts predict that by 2018, 20 percent of the economy will be spent on healthcare.

Despite this record spending, about 46 million Americans lack healthcare coverage. The President is committed to reform that assures quality, affordable healthcare for all Americans. Covering all Americans is not only a moral imperative, but it is also essential to a more effective and efficient healthcare system.

HHS has already made major strides towards this goal.

We have supported efforts at the Centers for Medicare and Medicaid Services such as the Children's Health Insurance Program, which has provided healthcare for millions of previously uninsured children.

The administration is using Recovery Act dollars wisely to protect coverage for families and help strengthen our healthcare system. The funds this subcommittee provided are protecting Medicaid coverage and improving health services to low-income Americans. The Recovery Act temporarily lowers the cost of COBRA coverage by 65 percent for some workers and their families, helping workers who lost their jobs hold onto the coverage they need.

The Recovery Act advances the President's health IT initiative and accelerates the adoption of health information technology—an essential tool to modernize the healthcare system—and the utilization of electronic health records. We are striving to improve care and give patients and doctors more information by devoting \$1.1 billion to comparative effectiveness research. In addition, we are working to improve the health of all Americans by investing \$1 billion in prevention and wellness.

These are important first steps, but there is much more work to be done to ensure all Americans have the high-quality, affordable coverage they deserve.

Consistent with the President's vision for a reformed healthcare system that offers affordable, quality healthcare to all Americans, the HHS budget invests in key priority areas and puts us on the path to health reform.

The budget sends a clear message that we can't afford to wait any longer if we want to get healthcare costs under control and improve our fiscal outlook. Investing in health reform today will help bring down costs tomorrow and ensure all Americans have access to the quality care they need and deserve.

Consistent with these principles, the budget takes a significant step towards comprehensive reform and establishes a healthcare reserve fund of \$635 billion over 10 years to finance health reform that brings down costs, improves quality, and assures coverage for all Americans. The reserve will be funded by new revenue and by savings from Medicare and Medicaid. While the reserve fund is a significant commitment, we are aware that this amount is not sufficient to fully fund comprehensive reform, and we look forward to working with the Congress to identify additional resources.

This saving proposal is supported by the following initiatives:

Aligning Incentives Toward Quality.—The budget includes proposals intended to improve incentives to provide high quality care in Medicare, including quality incentive payments to hospitals and voluntary physician groups and reduced payments to hospitals with high readmission rates.

Promoting Efficiency and Accountability.—The budget includes savings resulting from increased efficiency and accountability in Medicare and Medicaid, including reducing Medicare payments to private insurers by encouraging competition, implementing policies to decrease Medicaid costs for prescription drugs, improving Medicare and Medicaid payment accuracy, and bundling Medicare payments for inpatient hospital and certain post-acute care.

Encouraging Shared Responsibility.—The budget recognizes that successfully moving toward a reformed healthcare system will require all stakeholders to contribute a proportionate share. The budget includes a proposal to require certain higher-income Medicare beneficiaries enrolled in Part D to pay higher premiums, as is currently required for physician and outpatient services.

New Revenues.—Among other changes, the budget includes a proposal to limit the rate at which high-income taxpayers can take itemized deductions against revenues dedicated to health reform. This will help provide the savings needed to fund comprehensive health reform.

Improving Quality and Access to Health Care

At HHS, we continue to strive to find ways to better serve the American public, especially those citizens less able to help themselves. We are working to improve the quality of and access to healthcare for all Americans by supporting programs intended to enhance the healthcare workforce as well as the quality of health care

information and treatments through the advancement of health information technology (IT) and the modernization of the healthcare system.

The budget includes more than \$1 billion within the Health Resources and Services Administration (HRSA) to support a wide range of programs to strengthen and support our Nation's healthcare workforce. This funding will enhance the capacity of nursing schools, increase access to oral healthcare through dental workforce development grants, target minority and low-income students, and place an increased emphasis on ensuring that America's senior population gets the care and treatment it needs.

The budget also supports HHS-wide comparative effectiveness research, including \$50 million within the Agency for Healthcare Research and Quality. This research will improve healthcare quality by providing patients and physicians with state-of-the-science information about which medical treatments work best for a given clinical condition.

The budget advances the President's health IT initiative and accelerates the adoption of health information technology—an essential tool to modernize the healthcare system—and the utilization of electronic health records (EHR). The Office of the National Coordinator for Health Information Technology will continue its current efforts as the Federal health IT leader and coordinator. During fiscal year 2010, HHS will prepare to provide Recovery Act Medicare and Medicaid incentive payments to physicians and hospitals who demonstrate meaningful use of certified EHRs.

The Centers for Medicare and Medicaid Services (CMS) Program Management account increases by \$235 million in fiscal year 2010 to cover statutory and policy workloads in claims processing and in healthcare facility survey frequencies to adequately protect beneficiary quality of care and safety. CMS Program Management funding increases will also go to important initiatives such as ICD-10 implementation and additional funding for Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) implementation as well as the necessary increase in staff to administer new workloads from MIPPA and other recent legislation. CMS will also expand its research efforts to lay the groundwork for long-term reforms of CMS' programs and the Nation's healthcare system.

Delivering Human Services to Vulnerable Populations

HHS shares the President's belief in increasing access to critical services and healthcare for citizens most in need of assistance. HHS takes seriously our responsibility to reach out to those Americans least able to provide for themselves such as children and senior citizens as well as those in rural areas where quality, affordable healthcare and services are less accessible.

Due chiefly to Recovery Act funding, the Head Start program run by the Administration for Children and Families (ACF), will serve 978,000 children in fiscal year 2009, an increase of approximately 70,000 over fiscal year 2008. Approximately 115,000 infants and toddlers, nearly twice as many as in fiscal year 2008, will have access to Early Head Start services in fiscal year 2009 and fiscal year 2010. The budget includes an additional \$122 million to enable Head Start to sustain the historic increase in children served.

The budget includes \$178 million in funds to support evidence-based teen pregnancy prevention programs. To improve outcomes for women and children, the President's budget also assumes \$124 million for a new mandatory Home Visitation program to establish and expand home visitation programs for low-income families.

The budget includes \$3.2 billion for the ACF Low Income Home Energy Assistance Program (LIHEAP), one of the largest LIHEAP funding requests ever. Energy prices are volatile, making it difficult to match funding to the needs of low income families. For this reason, the budget includes a legislative proposal to provide additional mandatory LIHEAP funding if energy prices increase significantly.

The budget includes \$59 million, an increase of \$35 million, within the Substance Abuse and Mental Health Services Administration to expand the treatment capacity of drug courts. Within this increased funding for drug courts, \$5 million will support families affected by methamphetamine abuse. The budget also includes \$986 million, an increase of \$17 million, for the prevention and treatment of mental illnesses.

Securing and Promoting Public Health

Whether it's responding to the H1N1 flu virus or the recent recall of peanuts, HHS is responsible for keeping Americans healthy and safe, and we take that responsibility seriously.

The budget will help ensure we remain prepared to protect the American people. The investments we made in pandemic planning and preparation allowed us to re-

spond quickly and efficiently to the H1N1 virus in this country and helped get Americans the information and resources they needed early on during the outbreak.

The administration has requested supplemental funding to support the Federal response to the recent outbreak of 2009 H1N1 influenza. Resources will be vital to support the immediate response and to support potential longer term needs as determined by the severity of the virus in the Southern Hemisphere. It is important that we take steps now to ensure resources are available on a contingency basis in case they are needed. These funds, in addition to the fiscal year 2010 budget of \$584 million, will allow HHS to develop and produce vaccines as well as distribute antivirals, personal protective equipment, and other medical countermeasures. This funding will also support public health surveillance and response efforts in the face of the current outbreak.

HHS has been working diligently to ensure that the public will be protected from this H1N1 virus and has created an H1N1 virus reference strain that has been distributed to the manufacturers to create a virus master seed. HHS recently committed \$1.1 billion, through new orders on existing manufacturer contracts, to develop and test bulk supply of vaccine antigen and adjuvant for the production of pilot lots of an H1N1 vaccine. The Centers for Disease Control and Prevention (CDC), Office of the Assistant Secretary for Preparedness and Response, Food and Drug Administration, and NIH are working together to develop a commercial-scale vaccine production strategy, as well as working on the development of vaccine candidates.

HHS has also declared a nationwide Public Health Emergency; deployed teams to affected States according to the CDC Incident Action Plan; released 25 percent, or 11 million treatment courses of the antivirals in the Strategic National Stockpile for distribution to States; issued Emergency Use Authorization of diagnostic laboratory tests and to treat children under the age of 1 year with Tamiflu; issued regularly updated guidance for healthcare providers, public health officials, and the public on recommendations on antivirals, symptoms and reducing spread of the virus; and continued surveillance activities, particularly in the Southern Hemisphere to monitor the H1N1 virus.

People living with HIV disease are, on average, poorer than the general population, and Ryan White HIV/AIDS Program clients are poorer still. For them, the Ryan White HIV/AIDS Program is the payor of last resort because they are uninsured or have inadequate insurance and cannot cover the costs of care on their own, and because no other source of payment for services, public or private, is available. The budget includes more than \$3 billion in CDC and HRSA to enhance HIV/AIDS prevention, care, and treatment. Within HRSA, an additional \$54 million is included for the Ryan White HIV/AIDS Program to increase access to healthcare among uninsured and underinsured individuals living with HIV/AIDS and to help reduce HIV/AIDS-related health disparities. Within CDC, an additional \$53 million is included to enhance testing and other HIV/AIDS prevention efforts.

The President's request also includes \$354 million for combating health disparities and will help improve the health of racial and ethnic minorities and low-income and disadvantaged populations. This proposal includes \$143 million for the Minority AIDS Initiative under the Ryan White Act, \$116 million for Health Professions and Nursing Training Diversity Programs, \$56 million for the Office of Minority Health, and \$40 million for the REACH program administered by the CDC.

Rural Americans also often receive substandard care and the fiscal year 2010 budget includes \$73 million for a new "Improve Rural Health Care" initiative, which increases access and improves the quality of care in rural areas.

Investing in Scientific Research and Development

HHS is dedicated to finding better ways to treat and prevent illnesses such as cancer through the support of programs dedicated to advancing medical research and development. The HHS budget includes nearly \$31 billion for the National Institutes of Health (NIH) to continue support of biomedical research. These funds build on the unprecedented \$10.4 billion in total provided to NIH in the Recovery Act. Within the budget total, more than \$6 billion will support cancer research across NIH. This funding is central to the President's sustained plan to double NIH cancer research over 8 years. In fiscal year 2010, NIH estimates it will support a total of 38,042 research project grants, including 9,849 new and competing awards.

Recovery Act

The Department's portion of the American Recovery and Reinvestment Act of 2009 addresses and responds to critical challenges in our healthcare system and enhances human services through investments that immediately impact the lives of Americans.

The American Recovery and Reinvestment Act includes an estimated \$167 billion over 10 years for programs at HHS. HHS mandatory budget authority is increased by an estimated \$144 billion, which includes \$113 billion for Medicaid, \$23 billion for Medicare, \$7 billion for the ACF entitlement programs, and \$1 billion for administration. Most of the increase in this funding will take place in fiscal year 2009 and fiscal year 2010.

HHS also received \$22 billion in discretionary budget authority. The majority of these funds will be obligated by September 2010 to achieve the most rapid impact for citizens and States affected by the current economic downturn.

HHS Recovery Act activities support efforts to increase access to healthcare, protect those in greatest need, expand educational opportunities, and modernize the Nation's infrastructure. HHS is committed to quickly and carefully distributing Recovery Act funds in an open and transparent manner that will achieve the objectives of the Recovery Act. HHS released over \$16 billion in Recovery Act funds within the first 30 days of enactment, including crucial fiscal relief to States through increased Medicaid funding, funds for health centers, and funds for foster care and adoption assistance. Overall, HHS will distribute more than 90 percent of its increased discretionary funding, and approximately two-thirds of its increased mandatory spending, within 2 years of enactment.

Consistent with the President's call for accountability and responsible management in the Federal Government, HHS has established new policy and technical processes to review spending plans and to implement the Recovery Act requirements for transparency and accountability. To coordinate and manage the complexity of HHS' role and processes in the Recovery Act, HHS established an Office of Recovery Act Coordination run out of the Office of the Secretary. The Recovery Act also provides \$48 million for the Office of Inspector General to enhance accountability and enforcement activities to prevent waste, fraud, and abuse.

In Closing

Consistent with the President's vision for a safer, healthier, and more prosperous America, HHS will continue to seek improvements and strive to exceed expectations in areas such as securing and promoting public health, delivering human services to vulnerable populations, and improving quality of and access to healthcare. HHS will continue to make investments that will improve the lives of children, families, and seniors by creating a healthy foundation for everyone to fully participate in the American community.

Again, I would like to thank the subcommittee for this opportunity to offer my comments and I look forward to working with you to advance the health, safety, and well-being of the American people.

HEALTHCARE WASTE AND HOSPITAL-ACQUIRED INFECTIONS

Senator HARKIN. Madam Secretary, thank you very much for your summation and, as I said, your full statement will be made a part of the record in its entirety. Madam Secretary, there is an article in The Washington Post this morning on healthcare. It pointed out two important things. It says here, "The pockets of medical excellence dot the landscape, but at least 100,000 people die each year from infections they acquired in the hospital. While 1.5 million are harmed by medication errors." And down here, "yet The Institute of Medicine estimates that one-third of all medical care is pure waste such as duplicate X-rays, repeat lab tests, and procedures to fix mistakes."

[The information follows:]

[From The Washington Post, June 9, 2009]

DECISION MAKERS DIFFER ON HOW TO MEND BROKEN HEALTH SYSTEM

(By Ceci Connolly)

Nowhere else in the world is so much money spent with such poor results.

On that point there is rare unanimity among Washington decision makers: The U.S. health system needs a major overhaul.

For more than a decade, researchers have documented the inequities, shortcomings, waste and even dangers in the hodgepodge of uncoordinated medical serv-

ices that consume nearly one-fifth of the nation's economy. Exorbitant medical bills thrust too many families into bankruptcy, hinder the global competitiveness of U.S. companies and threaten the government's long-term solvency.

But the consensus breaks down on the question of how best to create a coordinated, high-performing, evidence-based system that provides the right care at the right time to the right people.

During eight years in office, President George W. Bush took an incremental approach, adding prescription drug benefits to the Medicare program for seniors and the disabled and expanding the number of community clinics nationwide. President Obama, like the last Democrat to occupy the White House, contends that was insufficient and is pushing for an ambitious reworking of the entire \$2.3 trillion system.

Framed by President Bill Clinton 16 years ago as a moral imperative to deliver health care to all, this summer's historic debate comes against a more urgent backdrop. As the national unemployment rate nears 10 percent and giants such as General Motors crumble, the expensive, inefficient health system has deepened the country's economic woes.

By virtually every measure, the situation has worsened.

Today, about 46 million Americans have no health insurance, so they go without or wait in emergency rooms for expensive, belated care. Everyone else helps pay for that Band-Aid fix in the form of higher taxes and an extra \$1,000 a year in insurance premiums.

Pockets of medical excellence dot the landscape, but at least 100,000 people die each year from infections they acquired in the hospital, while 1.5 million are harmed by medication errors. Of 37 industrialized nations, the United States ranks 29th in infant mortality and among the world's worst on measures such as obesity, heart disease and preventable deaths.

Bright young physicians trained at prestigious and expensive universities enter a profession built on perverse financial rewards. They, like assembly-line workers of the past, are paid on a piecemeal basis, earning more money not by doing better but simply by doing more.

Yet more care rarely translates into better health. Extensive research by Dartmouth College has found the exact opposite: Health outcomes are often best in communities that spend less compared with cities such as Boston and Miami where the medical arms race of specialists and high-tech gadgets often leads to greater risks and injuries.

The Institute of Medicine estimates that one-third of all medical care is pure waste, such as duplicate X-rays, repeat lab tests and procedures to fix mistakes.

"Most Americans don't understand how bad health care in the United States is," said Michael F. Cannon, head of health policy at the libertarian Cato Institute. "We need big reforms."

Across the ideological spectrum, the diagnosis is remarkably consistent.

"Sure, some people here have the best health care in the world, but the average American is paying too much and not getting enough in return," said John D. Podesta, who led Obama's transition team and heads the Center for American Progress, a think tank.

Said Sen. Judd Gregg (R-N.H.): "What's tragic is that so much of this spending is on duplicative or unnecessary care that doesn't improve health outcomes."

Simply put, the goal of health reform is to finally get our money's worth, say industry leaders, policymakers, consumers and business executives.

They envision a health-care system that guarantees a basic level of care for everyone, shifts the emphasis to wellness and prevention, minimizes errors, and reduces unnecessary and unproved treatment. Such a system would coordinate care, track patients and doctor performance electronically, and reward good results. The high-value system of the future would be organized "so that people get the care they need and need the care they get," said Elizabeth A. McGlynn, associate director of the health research division of Rand Corp.

Nowadays, that is often not the case.

On average, Americans receive the recommended, proven care 55 percent of the time, according to Rand studies. Sometimes, doctors or nurses overlook a basic but critical step, such as prescribing a beta blocker medication to patients after a heart attack, a therapy shown to significantly reduce the risk of a fatal attack. At other times, patients undergo procedures when there is no evidence that they are any better than a simpler, cheaper alternative.

Ten years ago, in its landmark report "To Err is Human," the Institute of Medicine estimated that 44,000 to 98,000 people die each year from medical mistakes, highlighting the need for improvement. Since then, the tally has risen, said Janet Corrigan, president of the National Quality Forum, a nonprofit membership organization that promotes quality standards.

"We now know estimates of those who die from hospital-acquired infections is upwards of 100,000," she said. "Many of those, if not most, are avoidable and preventable."

Sen. Robert C. Byrd's recent hospital stay, for example, has been extended because the West Virginia Democrat developed a staph infection.

"Everyone agrees that hospitals are hazardous to your health," said Mitchell Seltzer, a consultant who advises large medical institutions. "For every day a patient is in a bed, they are subjected to a higher probability of medical errors, hospital-acquired infections, inappropriate tests that do not have a direct bearing on the medical condition being treated."

Part of the problem is cultural, said Rand's McGlynn.

"People tend to demand the new thing even if there's not much evidence it will make a difference in the length or quality of life," she said.

Few patients or physicians have any idea who delivers good, or bad, care, because few organizations track results. Consumers have more information to evaluate their cars than they do their surgeons. "It's like a doctor flying the plane without instruments," said James N. Weinstein, a spine surgeon who directs the Dartmouth Institute for Health Policy and Clinical Practice.

Obama set aside \$19 billion in his economic stimulus package to promote the use of digital records, on the belief that they reduce duplication, produce more consistent care and cut down on errors.

Because the fee-for-service payment system rewards quantity over quality, there is little incentive—and there are even disincentives—for doctors, nurses and hospitals to improve, Corrigan said.

"Is it a surprise we have lots of extra imaging tests and lab tests?" she said. "Not at all."

The consequences are especially glaring in regions with larger numbers of specialists and pricey technology, the Dartmouth data show.

Take the case of Miami vs. La Crosse, Wis. In 2006, using inflation-adjusted figures, Medicare spent \$5,812 on the average beneficiary in La Crosse, compared with \$16,351 in Miami. Yet an examination of health status in both places, adjusted for age, finds no evidence that the extra spending resulted in better care, Weinstein said.

"That's the enigma here," he said. "Less is more, and more isn't better."

Physician behavior and spending patterns in Medicare have been good indicators of broader trends across the nation, Dartmouth has found.

Even the best physicians cannot stay current with all of the drugs, tests and treatments available today—another reason to digitize modern medicine, Corrigan said.

Many fear that the push to contain costs will result in rationing.

In today's system, "we don't ration care, we ration people," said Donald M. Berwick, president of the independent Massachusetts-based Institute for Healthcare Improvement. "We know that if you are black and poor or a woman, there are all sorts of effective interventions you are not going to get."

Though the transition would be painful and the politics treacherous, Berwick said it is possible to spend less on medical care and have a healthier nation.

"If we could just become La Crosse, think of how much better off we would be," he said.

Senator HARKIN. Madam Secretary, thank you very much for your summation and, as I said, your full statement will be made a part of the record in its entirety. So, as we look ahead for healthcare reform, people wonder how we are going to pay for all this. Well, if one-third, according to the Institute of Medicine, is pure waste, that comes out to be about \$700 billion a year. I don't know if that's right or not, but even if it's half of that, it seems to me that's an area where we could work together and, with the IGs office and others, to begin a really concentrated, concerted effort to look at where it is that we might make changes.

You, in your capacity as the Secretary, and where we might be able to work with you, should find those areas where we can cut down on the waste, and also determine what we can do to cut down on the number of infections that people acquire in the hospitals. It

is becoming dangerous to go to the hospital. More and more people are getting sicker in hospitals.

And so I just throw that out as saying that I hope you will be looking at this. You've just come on board, I know you've been there, what, a month-and-a-half now? Two months?

Secretary SEBELIUS. Six weeks, but who's counting?

Senator HARKIN. Six weeks, okay. Something like that. But I would hope that you and your staff would get together and look at this and see what it is that you can do, or what we can do together, to go after both of those elements.

Secretary SEBELIUS. Well, Mr. Chairman, let me just say that I appreciate the concern and share it. We have already issued a challenge to the American hospitals to work in conjunction with our Department to reduce, by two-thirds, the number of hospital-related infections. It has been proven that using a fairly simple hospital checklist has a dramatic impact on hospital infections. So, we are using some of the funding provided by Congress in the Recovery Act to do just that. To challenge hospitals, and also to increase the State capacity to do inspections. That's one area.

I don't think there is any question that we know where there are, as you say, pockets of high-quality, lower-cost medical care being delivered day in and day out, but they haven't been scaled across the country and there's a lot of excessive and redundant care right now that is probably not only costly, but doesn't really add anything to the health outcome. So that's another area of concern.

The comparative effectiveness research will help promote the best practices and share that patient-centered research about what helps and what is most cost-effective. But I can guarantee you that, in the Department, we are very focused on trying to identify what does work in a cost-effective manner and what drives the best health outcomes and hopefully share that across the country.

Health information and technology, again, funded in the Recovery Act will have, I think, a dramatic impact on lowering medical errors and sharing best protocols and putting some transparency behind what is effective or not.

So, you've already started down the pathway with the funding provided in the Recovery Act and there are some more investments in this budget that we hope move forward.

PREVENTION AND WELLNESS

Senator HARKIN. Madam Secretary, thank you for that response. As long as we are talking about the Recovery bill, a top priority for me was the Prevention and Wellness Fund. You mentioned some of it. Actually, we got \$5.8 billion in the Senate bill, the final amount was \$1 billion, but that's okay. We got it. \$650 million was dedicated to improve strategies to reduce chronic diseases. And we could have, obviously, specified exactly where we wanted all of this to go, but we left it sort of open, expecting that your Department, and the Appropriations Committee, would have an ongoing dialogue about what was the best strategy.

I've heard vague plans about a national media campaign. I don't know what diseases or conditions are being considered. I understand there might be community grants, but I don't know what's being targeted. I guess what I'm saying is that we need some more

specifics about how you're planning to allocate the Prevention and Wellness Fund. And I would like to have your assurance that you would consult with us, and have an opportunity for us to have meaningful input into this before it goes to OMB.

Secretary SEBELIUS. Well, Mr. Chairman, you have my assurance of that. As you know, Tom Frieden, who was named as the new Director of the Centers for Disease Control and Prevention, came on board on Monday, yesterday.

Senator HARKIN. Yes.

Secretary SEBELIUS. And I think that this is one of the significant investments in the Recovery bill and the most significant investment in prevention, granted significantly under where you hope it would end up, but still the most significant investment in prevention and wellness, I think in the history of the United States.

So, the leadership at the Department felt it was very important to collect a broad array of ideas and input and I can assure you that no final plans have been made. We wanted to get the leadership on board and we would be absolutely, not only willing, but delighted to consult with you as we move forward. Because sharing your expertise, I know this is an area that you are passionate about and have a lot of expertise to share, so we would very much look forward to coming back to you before a plan is finalized.

Senator HARKIN. Outstanding. Look forward to it. Thank you, Madam Secretary.

Senator Cochran.

Senator COCHRAN. Mr. Chairman, thank you. Madam Secretary, you know, one of the other responsibilities that I've had since being in the Senate is to chair the Agriculture Committee, in addition to this Appropriations Committee. And it occurs to me as we look at things that are done in the rural areas of the country, your Department, and the Department of Agriculture, share a lot or have some overlapping responsibilities. I wonder if you've thought about how maybe these can be coordinated and improved efficiencies or, in other ways, make available needed benefits like health screening, vaccinations, feeding programs. I just thought of those, the WIC program administration, for example.

In the case of a flu virus outbreak, it would be an important resource making available vaccinations. Do you have any thoughts about whether we need to improve the efficiencies of these programs by maybe combining that into one Department rather than having a division of responsibility between the two departments now?

Secretary SEBELIUS. Well, Senator, I can tell you that, in my short tenure here at the Department, I have already had a number of conversations with the Secretary of Agriculture, Tom Vilsack, who I served with as Governors in neighboring States. In Senator Harkin's home State, Tom Vilsack was the two-term Governor and he was actually Governor when I got elected, helped me get elected, and I have learned a lot from him.

So, there is a lot of collaborative discussion underway. Everything from food safety issues, as we redesign the food safety initiatives under the Food and Drug Administration, to looking at the obesity, food and nutrition in classrooms. A couple of the programs

that you mentioned we haven't had on our radar screen yet, but I think we definitely need to add those.

The President is very interested and committed to having Cabinet secretaries work in a very interagency fashion, leveraging the assets of the agencies and not replicating or duplicating programs that work well in one area, but borrowing good ideas and trying to work together in a collaborative fashion.

So, I think you've made some important suggestions and I will certainly circle back with those with the Secretary of Agriculture.

LIHEAP FUNDING DISPARITIES

Senator COCHRAN. The President's budget request creates a, or suggests that there should be created, a new mandatory LIHEAP program with a trigger mechanism for automatic increases in energy assistance. Under the current formula, these funds are distributed more to cold weather States than they are warm weather States, at least that's my observation.

When the new LIHEAP program is designed, how do you intend to address the funding disparity that endangers lower income residents in rural States in the South?

Secretary SEBELIUS. Well, Senator, I have to tell you that I wasn't aware of the disparity until I began some of the visits in preparation for my confirmation hearing. And it was raised by a number of warm weather Senators that the money runs out before it gets hot in the summertime.

And what I said at that point, and I intend to continue to do, is to take a look at the way that the funds are distributed. Because I agree with you, people are in jeopardy if they're sitting in 100 degree homes, the same way they are if they are in 30 degree homes. And the same kind of impact is had on vulnerable populations.

So, I can assure you that we would not only appreciate your input, but that I will certainly take into consideration, and ask the folks who are administering the program, if we are looking at the issues of warm weather States, because I think it is of concern.

Senator COCHRAN. Thank you. I have a couple more questions, but I am going to yield to other senators who are here.

Senator HARKIN. Senator Kohl.

Senator KOHL. Thank you so much. Secretary Sebelius, welcome.

Secretary SEBELIUS. Thank you.

Senator KOHL. As you know, the waiver for Wisconsin's Senior Care Program is scheduled to end on December 31 of this year. Currently, this program provides over 100,000 seniors in my State with high-quality, cost-effective prescription drug coverage, as I presume you are aware. According to the CBO, it does so while achieving ongoing savings for the Federal Government at the same time.

I understand that Governor Jim Doyle, who I know you are very familiar with has applied for a waiver to extend senior care through 2012, which should allow this very successful program to continue. Can you tell me the status of the waiver application and whether or not we can hope to achieve that waiver?

Secretary SEBELIUS. Well, Senator, as you know, that 1115 Program is the only one left in the country where the State-only drug program is being conducted. And I know it's wildly popular and I

know it's been enormously successful. You'll be pleased to hear that not only did my good friend, Jim Doyle, apply for the waiver of continuation before I got to the office, but he was in my office 3 days ago amplifying that request, to make sure that I did not forget. And, as you might be aware, the President is going to Green Bay, Wisconsin on Thursday to talk about healthcare reform and I don't doubt that he's going to hear a little bit of something about this popular program.

It is my understanding that we're in the final stages of review, that people in the Agency are aware of not only how popular it is, but how successful it's been. And I'm hopeful that we will be able to give you news in the very near future.

Senator KOHL. Well, I'll take that as a somewhat positive indication.

Secretary SEBELIUS. I just don't have the definitive answer today. I'd hoped I'd have it by today, but close.

Senator KOHL. Okay. I happen to have given a speech on Monday in Wisconsin to 400 people who are involved in issues that apply to seniors all across our State and I had something like a dozen applause lines written into my speech. The only one that got any applause—

Secretary SEBELIUS. Was this program.

Senator KOHL [continuing]. Was my reference to the senior care program and how effective it's been.

Secretary SEBELIUS. Well, I can tell you in the discussions that I've been involved in healthcare reform, I have asked our folks, just because before I came to this position, as a Governor and as someone who shared ideas with other governors, not only did I have our State looking at how successful Wisconsin had been and what kinds of things we could do to mirror it, but the healthcare reform team has the whole program and we want to look at it as a possibility to include as one of the options.

So, it definitely has caught the attention of lots of folks outside of Wisconsin.

QUALITY OF HEALTHCARE

Senator KOHL. Thank you.

Secretary Sebelius, lately, as I'm sure you're very much aware, there's been much media attention on how it costs two to three times as much to fund a Medicare recipient in some locales across our country than it does in others. We've seen articles in several publications come to the conclusion that healthcare quality does not increase with higher spending. In fact, The Washington Post reports that healthcare costs in a place in my State, Lacrosse, are much lower than the national average and yet quality is much better than the national average.

I'm sure this is one of the toughest, one of the toughest problems that you are going to be confronting in your time as Secretary. Do you have some initial thoughts on what we can do to take advantage of those areas that are doing a great job in controlling costs and extend it across the country to those areas that are not?

Secretary SEBELIUS. Well, Senator, I think you've just very adeptly defined the challenge as how to take what is happening in pockets, as Senator Harkin said earlier, across the country and sort

of scale up. So not only do we reduce overall costs, but we increase quality.

Someone said to me the other day that, you know, there's a lot of discussion about rationing healthcare. And this expert said that he thought what we were doing currently in America was rationing quality, which I thought was an interesting lens. I think the comparative effectiveness research that was funded, \$1 billion worth in the Recovery Act, is a big step in that direction. To inform doctors and consumers, patients, what is happening and what the best practices are. I think there are certainly NIH studies which can lend to that and CDC is looking at areas that we can improve quality.

But part of it is learning from the folks who are running the health systems that have been identified as delivering high-quality care at a much lower cost. We have some improvements currently proposed in the budget and some Medicare demonstration projects. One of the areas we know is very erratic is what happens to a patient when you get released from a hospital. Right now, 20 percent are re-admitted. And a lot of evidence leads to the fact that that's because of a lack of follow-up care, which is very expensive and certainly not great for the patient. So, we're trying to expand best practices in that area.

Looking at bundled payments so providers are more concerned with ultimate outcome and not with contacts with patients. So we think that will be an effective strategy. And really driving, encouraging some voluntary collaboration, with single practice docs so that they can have a more coordinated care strategy.

So trying to take what we think is working and encourage others to follow that practice and use some of the Medicare, both incentives and payments, to enhance and accelerate quality care for all Americans.

Senator KOHL. Thank you very much. Thank you very much, Mr. Chair.

Senator HARKIN. Thank you, Senator. Senator Alexander.

Senator ALEXANDER. Thank you, Mr. Chairman. Madam Secretary, welcome. I'm glad you're here.

The President sent a letter to Senator Baucus and Senator Kennedy saying that, on June 2, saying that healthcare reform must not add to our deficit over the next 10 years and today he made a speech about pay-go, saying that we should only spend a dollar if you save, or I might add tax a dollar. Are we to assume then that so-called pay-go should apply to the healthcare reform bill that we are considering in Congress.

Secretary SEBELIUS. Well I think, Senator, certainly the estimates over a 10-year period of time are a bit difficult to reach. And I think one of the ongoing concerns, and it is something that I think the chairman shares, is that currently there is no scoring, for instance, for any prevention and wellness strategy. I'm not sure there's an expert who believes that it won't save money, and yet it is not scored.

So, whether or not the kind of transformational healthcare reform will actually have a dollar-for-dollar offset on day one, I can't tell you because I think that—

Senator ALEXANDER. So, pay-go does not apply to the healthcare reform bill we are considering?

Secretary SEBELIUS. Senator, I think it does. I haven't seen the outlines of exactly what the President is proposing to Congress. I know there was some discussion, about the 10-year timeline with the healthcare reform bill. Is it 10 years from the date it starts, is it 10 years from the date it passes? And there is a lively debate about prevention and wellness strategies and whether that can be scored at least in out-years.

Senator ALEXANDER. But would you agree that it might be a good idea to see the details of the proposal and to hear from the Congressional Budget Office what the scoring might be before making a decision about going forward, in light of the President's concern about pay-go?

Secretary SEBELIUS. Well, I think certainly it is a discussion to have. I'm not sure that the Congressional Budget Office is going to score prevention, although I think they're dead wrong in not assuming that there will be savings and cost effectiveness related to shifting a health system to a wellness prevention system.

Senator ALEXANDER. Well, without being overly redundant, if the President is going to write us a letter and say don't add to the deficit and give us a lecture about pay-go, shouldn't it apply to the healthcare reform bill, which is variously estimated between \$1 to \$2 trillion in new costs over the next year?

Let me ask you this, if it does cost between \$1 to \$2 trillion, depending upon whether it's the Kennedy bill or the bill being considered by the Finance Committee, what new taxes or what new savings would the administration recommend to make sure that we don't add to the deficit?

Secretary SEBELIUS. Well, Senator, as you probably know, in the 2010 budget, the President recommended about \$630 billion worth of both savings and revenue enhancements. And we've also suggested, after reviewing the overall Medicare programs, that within the Medicare program, we think another \$200 to \$250 billion is possible in terms of savings. There's no question that the additional and enhanced efforts on fraud and abuse will generate some additional savings. And he has had lively discussions with members of the House and the Senate about their ideas for funding the remainder of the program.

But I think the good faith effort by the President, and it's demonstrated in his budget and moving forward, to come in with a substantial investment in reform moving forward, and then hopefully engaging Congress in that very discussion.

Senator ALEXANDER. But you would agree that the investment is only a beginning of the amount of money that we may need?

Secretary SEBELIUS. Well, \$634 billion plus another \$200 billion is \$800 billion. And if it is in the \$1 trillion to \$1.2 trillion range, that's a pretty good investment moving forward.

Senator ALEXANDER. That's a pretty good investment, so it would be important to know the details of the proposal and the cost of the proposal before we vote on the proposal and act on the proposal, if we are to take, show respect to the President's desire for pay-go and not adding to the deficit.

Secretary SEBELIUS. Well, and hopefully as Members of Congress engage in this discussion, as the bill is written by the Finance Committee and the HELP Committee, the three committees dealing with it in the House will engage in those conversations about paying for healthcare reform, which will be a critical part of this dialogue moving forward.

A PUBLIC HEALTH INSURANCE OPTION

Senator ALEXANDER. Does the President or the administration support the Government-run insurance plan proposed by Senator Kennedy in his legislation? I note that the President, in his letter, said that he wanted to see a public or Government-run option as a part of a plan.

Secretary SEBELIUS. Well, I think that the President has maintained from the outset, during the course of the campaign and in the letter that you received, that in the Health Insurance Exchange, a marketplace where consumers would have choices and options for coverage if they want to choose new coverage, that a public option is very important. In many parts of the country, there is not a choice of private plans. There is a dominant carrier, a monopoly—

Senator ALEXANDER. Excuse me, but does he support or not support Senator Kennedy's—

Secretary SEBELIUS. I have not seen the specific language that you are referring to—

Senator ALEXANDER. So, he would want to read it and understand it and understand it and maybe see the cost of it before he made that decision.

Secretary SEBELIUS. You'd have to ask the President about that.

Senator ALEXANDER. Well, I'm asking—you represent him, would you want to read it and understand it?

Secretary SEBELIUS. And I will.

Senator ALEXANDER. And know the cost of it before you decided whether you supported it.

Secretary SEBELIUS. I'm sure we'll have that dialogue.

Senator ALEXANDER. Does that mean you would or you wouldn't?

Secretary SEBELIUS. I said I would read it, yes sir.

Senator ALEXANDER. So, you would want to read it and understand the cost before you decided whether to support it.

Secretary SEBELIUS. Yes, I will read it.

Senator ALEXANDER. Thank you, Mr. Chairman.

Senator HARKIN. I just want to make sure my colleague from Tennessee, who is also a member of the authorizing committee, I believe, right?

Senator ALEXANDER. Yes.

Senator HARKIN. That we're going to have a walk-through with our bill starting tomorrow, both Republicans and Democrats, that the Senator will have every opportunity to amend, offer, discuss these different things. I can tell you to right now that we're on this public option plan, that we're leaving it blank, because we want to have a discussion on it. And we want to have ideas that come forward, and see where the votes are. I think that's the fair and honest way to do that.

So, we're not coming out with anything and saying here is, take it or leave it. We are kind of leaving it open for discussion and then I we'll see where the votes are on it. I think that's the best way to proceed.

And then, after that, whatever we decide to do, then the administration can tell us what they think, but that's our deal and we have to do it.

Senator ALEXANDER. I thank the chairman. I just wanted to establish the principle that it is usually a good idea to read and understand know the cost of a proposal before we are asked to make a decision about it.

Senator HARKIN. Oh, I think that will happen in the next couple months. Senator Pryor.

Senator PRYOR. Thank you, Mr. Chairman, and thank you, Madam Secretary, for being here.

Let me start, if I may, with the issue of Comparative Effectiveness Research. And my understanding is that this research has great potential to empower patients and physicians to choose treatments that offer the most benefit; however, some have attacked this initiative, claiming that it could be used to ration care.

Do you mind talking to the subcommittee for a few minutes about Comparative Effectiveness Research and why you think that the Department is in a better position than the private sector to ensure this research is performed?

Secretary SEBELIUS. Well Senator, I think that, first of all, to the point you made citing detractors who are fearful that this will lead to rationing care, there is a provision in the funding of the research that prohibits Medicare from using Comparative Effectiveness Research to make cost decisions. I think that is clear in the law and certainly the folks at the Centers for Medicare and Medicaid Services (CMS) intend to follow the law.

We are very encouraged by the opportunity to learn from what's happening in this rapidly evolving area of medical care and certainly what is happening to produce high-quality, low-cost care in various parts of the country. And to help drive those best practices across the country, so all Americans have access to that care. And I think that the investment that Congress wisely made in Comparative Effectiveness Research gives us the opportunity to do that, to tie in what strategies lead to better health outcomes and lower cost which are, again, in places in pockets around the country, but not everywhere.

And I think the fear is that somehow this will drive rationing of care. I will suggest it will raise quality of care in a very effective manner.

HEALTHCARE ACCESS IN RURAL AMERICA

Senator PRYOR. Let me ask another question, something that I know is important to you, being from a rural State like I am. And that is that we have a real challenge in our State, as well as other senators do in their home States, where we just don't have enough doctors in rural America.

And my sense is that, you know, one reason is because a rural setting and the challenges for a rural practice just isn't that appealing for a lot of people coming out of medical school. But also,

I think that there is a practical part of this and that is that the Medicare reimbursement rates are often much lower in a State like Arkansas, and may be your home State, and elsewhere than they would be otherwise.

Secretary SEBELIUS. We like to call you "Our Kansas" but—

Senator PRYOR. I understand, I understand. We get that a lot by the way. But we do share that, so my question for you is, what is the best way to ensure that people in rural America have, not access to coverage, but actually access to care in their home communities?

Secretary SEBELIUS. Well, I think it's a great question and certainly one that I worked on as Governor in Kansas, and I share your concerns about the distribution of healthcare providers and the incentive to stay in practice in a rural community.

Certainly continuing to examine the pay differentials of Medicare is a piece of the puzzle and one that I take seriously and will make sure that we continue to look at. Whether or not that provides disincentives for all kinds of things. There are people who suggest that there are also disincentives for lower-cost care to be delivered in some areas because then they turn around and get penalized with lower reimbursement rates.

I think there's a lot that the investment that you made in health technology can also do to enhance rural practitioners by connecting with telemedicine to specialists and consultation experts who may be hundreds or even thousands of miles away, but can be very much part of their practice on an ongoing basis. And certainly the investment in the Expanded Commission Corps to look at underserved areas is a help, as well as the money—we just announced a couple of days ago, pushing out the door some of the Recovery Act money which will help pay student loans. And I know, at least in our State and I'm sure in Arkansas, the payment strategy for underserved areas has been particularly effective in having young providers locate. And once they are there, they don't leave, that has been our experience.

So, I think we've got to use a whole variety of incentives, loan repayment, telemedicine, to make sure that all Americans have high-quality care.

Senator PRYOR. Well, and I do appreciate the President and you putting into the budget the Improved Rural Health Care Initiatives. So, I think that's a step in the right direction. Thank you for your answer.

Mr. Chairman.

Senator HARKIN. Thank you, Senator. Senator Specter.

Senator SPECTER. Thank you, Mr. Chairman. Madam Secretary, thank you for taking on this difficult job and leaving the beautiful State of Kansas.

Secretary SEBELIUS. Our home State, I share with the Senator, yes.

Senator SPECTER. Today has been a Kansas Day in appropriations hearings. Secretary Gates testified this morning. He's from Wichita.

Secretary SEBELIUS. Yes, indeed.

Senator SPECTER. And went to a very distinguished grade school.

Secretary SEBELIUS. We're talking about Kansas, it's important.

Senator SPECTER. He went to a very distinguished grade school and it's called College Hill. It only went to the sixth grade. And I went there not quite at the same time, but the same school. And the Governor is from Kansas in a town not too far from Russett.

NIH FUNDING

So much for the pleasantries, Governor. Now on to your budget. To have an NIH budget of \$442 million is a sharp retreat from what the chairman used to insist on, \$3.5 billion a year increases. Senator Harkin wouldn't settle for any less than that for most of a decade. Well, I guess that's not entirely true, occasionally he settled for \$3 billion. But if you take a look at the cost-of-living adjustments, the inflation rate, about 3.3 percent, that's \$1 billion.

I know you don't construct the budget all by yourself, OMB, there are lots of constraints, but I would urge you to take another look at that figure. We can offer amendments, of course, to stay within the budget, but I appreciate it if you would take another look at it.

The \$10 billion which was added in the stimulus package has created an enormous wave of excitement among young people. We are in jeopardy of losing a generation of young research scientists and I think we have to maintain the growth rate. We talk about cutting down the costs of healthcare, what better way to cut the cost factor than to prevent illness. And during the period of time when Senator Harkin had his way, increasing from \$12 to \$30 billion, the death rate from—

Senator HARKIN. Wait a minute, I was ranking member.

Senator SPECTER. What's that? Now, come to think of it, he didn't have all that much to do with it. But on a serious note, we used to trade gavels with some frequency. But on to the serious note, the death rate from strokes went down, from heart disease, improvements on cancer. And we just have to find some way to do better.

And I note that the budget calls for \$268 million for cancer and \$19 million for research into autism. That is a change from what we've always done. We'll have endeavored not to politicize the allocations by leaving it to the scientists. And one year the chairman of the Appropriations Committee who suffered from prostate cancer wanted to add \$150 million to prostate cancer and he was unsuccessful in doing that.

So, I'd like you to take another look. And I know you can't focus on all of these matters and you don't have a long history like this subcommittee as to whether you really want to initiate a policy of picking and choosing.

UNIVERSITY OF PITTSBURGH BIODEFENSE INITIATIVE

My yellow light is on so I will make only one further comment. I want to express my thanks to you for meeting with a group by May 20 on the Biodefense Initiative from the University of Pittsburgh, UPMC. Do you have any initial thoughts on that subject? I know you haven't had time to go through it in detail, but any preliminary thinking? I don't get calls from UPMC more than twice a day, so when I have you here, I thought I'd ask.

Secretary SEBELIUS. Well Senator, I thought, first of all, the presentation was very impressive and certainly the notion that we should have a facility dedicated to production of a variety of vaccine lines is also incredibly timely and something that I think should be part of our preparedness arsenal.

I think that the issue that we're facing right now, as you well know, is whether we can adequately prepare for the uncertainties that still may be confronting us in the very near future with novel H1N1 strains, and the potential massive vaccination program, and production costs, and continue with the preparedness underway. And then add an additional factor to that. But I don't think there's any doubt about the importance about that being part of the strategy moving forward, but how quickly that could be implemented, I can't tell you right now.

Senator SPECTER. Well, we would appreciate your informing us at the earliest date you can.

Secretary SEBELIUS. I will, Senator. Thank you.

Senator SPECTER. Thank you, Madam Secretary and thank you, Mr. Chairman.

NIH STIMULUS FUNDING

Secretary SEBELIUS. And Senator, may I just respond briefly to the research questions, because I just want to tell you that I share both the concern that we continue to invest in science and research. And I have already heard enormously positive feedback about the investment from the Recovery Act and, as you say, the excitement of a new generation of researchers that we are committing to research funding.

I do think that, in putting together the 2010 budget, there was a recognition that the Recovery Act funds really will fund 2010 and some of the 2011 strategies. But working with you, Senator, not only Senator Specter, but the chairman, who I know has enormous interest in this research area, on future years I think will be very important to make sure that we don't reach a cliff and fall off the edge of the cliff, because we want to continue this multi-year research investment.

Senator SPECTER. Well, Madam Secretary, may I suggest that the stimulus package and that \$10 billion ought not to be looked at for the regular funding. That is extra, designed to create 70,000 new jobs for the 2-year period, with the specific target that the President asked for and that Congress responded to in an affirmative way.

I perhaps, as much as any, under the circumstances casting the vote I did, that we were looking for that to stimulate the economy and for jobs. And I couldn't tell you, line by line, on all the other budget items, but I believe that it was not a generalization for the stimulus to be used in place of the future years' funding.

So we'd like to maintain NIH funding on its own, besides that.

Senator HARKIN. Madam Secretary, I just want to say that I fully concur with Senator Specter's views on this. We have worked in tandem on this for a long time and I can assure you that, when it comes to NIH funding, regardless of which side Senator Specter is on, he is going to be dogged on this and I am going to be joining with him on it.

Senator Specter is absolutely right. We put that money in there, in the stimulus, because it was stimulus for the 2 years. And I am concerned about the cliff and the baseline and what happens to that baseline funding.

Quite frankly, if you really look at it, Senator Specter, we finished that from about 2005 until now, basically our funding has been kind of flat. I think that in real dollars we are about at where we were in 2005, if I'm not mistaken. So, to only put in \$442 million doesn't do much for getting our baseline up.

Senator SPECTER. Mr. Chairman.

Senator HARKIN. Yes.

Senator SPECTER. During the period of the last several years, you and I made the calculation we went down \$5.2 billion in real dollars.

Senator HARKIN. Real dollars, yeah.

Senator SPECTER. As a result of not having a cost-of-living adjustment for several years and then these tiny across the board cuts, a percent here and half a percent there, and pretty soon a \$30 billion allocation turns out to be less than \$25 billion. So, were playing against that backdrop as well.

Senator HARKIN. So, this one thing we can probably concur on, I don't know about the second, but the \$442 million is, I think, inadequate. We'll see what we can do about that. I don't know, within our allocation, what we can do. We don't have our allocation yet, we'll have to see about that. But we have a lot of demands for this and we'll just have to see what we can come up with.

But within that \$442 million, I am somewhat concerned that \$268 million was designated for cancer, for the National Cancer Institute, and I think, \$19 million for autism. So, over half of that for two Institutes, for two diseases. And I mentioned this to the NIH Director, Acting Director, who was up here looking at their budget, that I don't know if this is a good way to do things. To put all that money just into those two programs, when there's a lot of other needs spread across the entire spectrum of research.

And I'm just thinking that, perhaps, we might look for a better distribution of the money than just in those two areas. Let the researchers at NIH decide where that money ought to go.

Secretary SEBELIUS. I appreciate that.

Senator HARKIN. I don't have anything else, Madam Secretary.

HEALTHCARE FRAUD AND ABUSE

Senator COCHRAN. Mr. Chairman, I have one other question, if I may.

Madam Secretary, I've been advised that fraud and abuse are draining about \$60 billion a year from our healthcare system. This money could be going to patient care and to address other problems. I've co-sponsored, with other senators, The Seniors and Taxpayers Obligation Protection Act, as an acronym STOP, it's known as the STOP Act, which is designed to eliminate the use of Social Security numbers as the Medicare identifier to help curb fraudulent services.

I wonder if you agree that something like that is needed and, in view of the fact that your budget includes only \$113 million for

Medicare safeguards, do we need to look elsewhere for ways and means of helping to curb Medicare waste, fraud, and abuse?

Secretary SEBELIUS. Well, I certainly share your concern about waste, fraud, and abuse, Senator. And any dime stolen from the program is stolen from not only the taxpayers, but from the delivery of healthcare services. And I think that's why the President was eager to have the Attorney General and I join together in a new initiative sharing real data, rather than following what were sometimes old audits, trying to get out ahead of some of this effort by monitoring billing.

And I am not familiar specifically with the legislation you mentioned, but I will certainly share those ideas with our folks and have them take a look at it. Because I think that anything we can do to discourage these practices before they occur and save those resources for the delivery of healthcare is incredibly important.

People are stealing from the system and we want to make it more difficult, if not impossible, not easier. So, this is one strategy that I would love to take back to our CMS folks.

Senator COCHRAN. Thank you very much. Thank you, Mr. Chair.

Senator HARKIN. Thank you, Senator Cochran.

ADDITIONAL COMMITTEE QUESTIONS

Well, Madam Secretary, thank you very much for your appearance here and your leadership at the Department. I will leave the record open for any written questions that the Senators who couldn't be here might want to propound. And, again, I look forward to working with you on the recovery money that we talked about before that's going out for prevention.

Secretary SEBELIUS. Absolutely. Thank you.

[The following questions were not asked at the hearing, but were submitted to the Department for response subsequent to the hearing:]

QUESTIONS SUBMITTED BY SENATOR DANIEL K. INOUE

OCCUPATIONAL SAFETY AND HEALTH TRAINING PROGRAM

Question. Several years ago, at my request, the Centers for Disease Control and Prevention (CDC) established a National Institute for Occupational Safety and Health presence at the University of Hawaii at Hilo. Unfortunately, a now retired faculty member returned the funds. With new and energetic faculty now present, will you consider re-establishing a presence back on the island, given our truly unique rural and environmental needs?

Answer. CDC/NIOSH supported a Training Project Grant at the University of Hawaii—Hilo (T02—OH008627, entitled “Occupational Safety and Health Education—A Behavioral Approach,” from August 2001 through June 30, 2006. The awarded application was competitively reviewed and was awarded based on its technical and scientific merit. The Principal Investigator, Dr. Stephen Worchel, Department of Psychology, indicated to CDC/NIOSH in August 2005 that the University did not plan to re compete for support of this project. The grant ended and was subsequently closed out.

On March 12, 2009, CDC/NIOSH provided a step-by-step process for submitting a new application to University of Hawaii at Hilo for a Training Project Grant. University officials indicated that the University of Hawaii—Hilo planned on submitting a highly competitive application for the upcoming August 24 deadline in response to NIOSH's Program Announcement PAR-06-484: <http://grants.nih.gov/grants/guide/pa-files/PA-06-484.html>. The most meritorious applications are expected to be funded in June 2010.

NATIVE HAWAIIAN HEALTHCARE

Question. I am very pleased that your department continues to recognize the unique health needs of the Native Hawaiian population. I appreciate being kept informed of efforts to improve health outcomes, especially as they relate to diabetes and cancer in this population.

Answer. The Department of Health And Human Services (HHS) has a number of initiatives, grants, and partnerships to address the needs the Native Hawaiian population; attached is a list of some of the grants provided to organizations serving Native Hawaiians. In 2006, HHS established the HHS Workgroup on Asian, Native Hawaiian and other Pacific Islander Issues (WANHOPII). The mission of WANHOPII is to improve communication, coordination, and agency policies, programs, and evaluations that impact the health, healthcare, human services, and well being of Asian American, Native Hawaiian and other Pacific Islander (NHOPI) communities. In addition, the Office of Minority Health is supporting the development of the Native Hawaiian and Other Pacific Islander Health Agenda, including town hall meetings and summits that provide a forum for NHOPI community members, community-based organizations, and others to voice their issues, concerns, and recommendations, and to mobilize around a health and well-being agenda to address NHOPI health.

Several HHS offices and agencies have programs to improve health outcomes, including those related to diabetes and cancer, of the Native Hawaiian population. Summaries are provided below:

OFFICE OF MINORITY HEALTH

The Office of Minority Health (OMH) supported the development of the Native Hawaiian and Other Pacific Islander Health Agenda introduced by the Asian and Pacific Islander American Health Forum (APIAHF), and provided additional funding to APIAHF to explore health issues facing Native Hawaiians and Pacific Islanders.

In April 2007, OMH supported the California Native Hawaiian and Pacific Islander Town Hall Meeting to provide a forum for NHOPI community members, community-based organizations, and others working with NHOPI populations to voice their issues, concerns, and recommendations regarding NHOPI health to the HHS. The town hall and subsequent discussions resulted in the first ever Native Hawaiian and Pacific Islander Health and Well-Being Summit in October 2007 to articulate and mobilize around a health agenda. HHS recognizes that NHOPI communities have unique health needs, and has supported APIAHF in the formation of the Native Hawaiian and Pacific Islander Alliance. On January 30, 2008, APIAHF with the NHPI Alliance released the report "Guidance for the classification of Native Hawaiians and Pacific Islanders" that appropriately reflects the disaggregation of Asian Americans, Native Hawaiians, and Pacific Islanders.

In April 2009, OMH co-sponsored the Native Hawaiian and Pacific Islander Health Brain Trust, hosted by the APIAHF. The 2009 Brain Trust was the first of a two-series conference to learn about pressing health issues and discuss barriers to data collection and reporting on Native Hawaiians and Pacific Islanders, and to identify strategies for community and community-based organizations, researchers, funding agencies, policy makers, and advocates for improving the health and well-being of Native Hawaiians and Pacific Islanders.

OMH also works closely with our community partners, including Papa Ola Lokahi, to respond to the concerns and needs of the Native Hawaiian community. Through the Youth Empowerment Program, OMH supports the Lanakila Learning Center through the University of Hawaii at Hilo. The Lanakila Learning Center is an alternative learning center of Hilo High School servicing "at-risk" 10th-12th graders, and providing a variety of wellness workshops in substance abuse prevention/intervention, social skills training, anger management, health and nutrition, and fitness classes.

Through the Community Partnerships to Eliminate Health Disparities grant program, OMH supports the Life Foundation, a program that seeks to improve the health status of Native Hawaiians, Asians, and Pacific Islanders through targeted HIV prevention and care services. Life Foundation partners with Waikiki Health Center and Waianae Coast comprehensive Health Center.

HEALTH RESOURCES AND SERVICES ADMINISTRATION

The Health Resources and Services Administration (HRSA) provide funding for the Native Hawaiian Health Care Program, which is funded through the Health Center appropriation. The focus is to improve the health status of Native Hawaiians by making health education, health promotion, and disease prevention services

available through the support of the Native Hawaiian Healthcare Systems. The Native Hawaiian Healthcare Systems use a combination of outreach, referral, and linkage mechanisms to provide or arrange services. Services provided include nutrition programs, screening and control of hypertension and diabetes, immunizations, and basic primary care services. In fiscal year 2007, Native Hawaiian Healthcare Systems provided medical and enabling services to more than 6,500 people. The Native Hawaiian population is also served by the Health Centers operating more broadly across Hawaii.

NIDDK'S DIABETES EDUCATION IN TRIBAL SCHOOLS (DETS) PROJECT

The National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) has provided funding to eight tribal colleges and Universities to develop supplemental curricula on diabetes education for K–12 schools that educate American Indian and Alaska Native children. The curricula are completed and the investigators are now recruiting and training teachers in the K–12 schools. Recently, the investigators were invited by some schools in Maui to provide professional education to their teachers so they can also use the DETS curricula to teach children in their K–12 schools about diabetes and prevention. You may find more information on the DETS at: <http://www3.nidk.nih.gov/fund/other/dets/index.htm>.

HHS NATIONAL DIABETES EDUCATION PROGRAM

The HHS National Diabetes Education Program (NDEP) is the leading Federal Government public education program that promotes diabetes prevention and control. Launched in 1997, NDEP's mission is to reduce the morbidity and mortality associated with diabetes. More than 200 organizations and many volunteers have joined with NDEP to help develop critical and effective initiatives. The NDEP Asian American and Pacific Islander Work Group has led development of tip sheets on comprehensive diabetes control and the primary prevention of diabetes in 15 Asian and Pacific Islander languages. Through the CDC, the NDEP supported Papa Ola Lokahi's Pacific Diabetes Education Program, serving Native Hawaiians and a diverse population across the Pacific Islands with culturally appropriate in-language diabetes materials.

The Hawaii Diabetes Prevention and Control Program (HI DPCP) has received funding from the CDC since 1987. Activities supported by the DPCP include surveillance, development of the Hawaii Diabetes Coalition, translation, development and distribution of resource materials, quality improvement initiatives, and review of the Hawaii State Practice Recommendations.

CENTERS FOR MEDICARE AND MEDICAID SERVICES

Many of the Centers for Medicare and Medicaid Services (CMS) activities have focused on the Native Hawaiian healthcare system (Papa Ola Lokahi is the lead agency) along with grants to various Federally Qualified Health Centers (FQHCs) and community health centers. CMS also funds a Cancer Prevention and Treatment Demonstration for Racial and Ethnic Minorities (ending in 2010) at Molokai General Hospital. The demonstration is using a randomized control design to study the impact of various evidence-based, culturally competent models of patient navigator programs designed to help minority beneficiaries navigate the healthcare system in a more timely and informative manner and facilitate cancer screening, diagnosis, and treatment to improve healthcare access and outcomes as well as potentially lower total costs to Medicare. Approximately 12,700 Medicare fee-for-service beneficiaries are eligible to be enrolled in the study during this 4-year project.

Through CMS-funded grants directed to States, State Health Insurance Assistance Programs, or SHIPs, provide free counseling and assistance to people with Medicare and their families. The Hawaii SHIP provides the following activities:

- Part D/LIS and general Medicare counseling, information and outreach to beneficiaries and information on how the plans will coordinate with the unqualified SPAP which will lead to improved access to medications by beneficiaries. While this is not specifically targeted to diabetes and cancer health outcomes, these activities will help improve access to needed medications for this population.
- Through the Executive Office on Aging of the Department of Health where the SHIP is housed, the Native Hawaiian programs participate in the Healthy Aging project.

ADMINISTRATION ON AGING

With funding from the U.S. Administration on Aging, Hawaii's Executive Office on Aging and Department of Health work together to offer Healthy Aging Partner-

ship—Empowering Elders (HAP-EE), which began in September 2006. HAP-EE carries out programs that have been proven effective in reducing the risk of disease, disability and injury among the elderly. These include the Chronic Disease Self-Management Program, Arthritis Self-Management Program, Diabetes Self-Management Program, and EnhanceFitness. These programs provide seniors with simple tools and techniques they can use to better manage their chronic conditions, reduce their risk of falling, and improve their nutrition and physical health. A pre-poststudy of the Hawaii Chronic Disease Self-Management Program reported improvements in physical activity; reductions in pain, fatigue and shortness of breath; and a reduction in medical care use. Results of pre-poststudy of Enhance Fitness participants in Hawaii showed improvements in gait and strength, increased levels of physical activity, and reduction in falls.

CENTERS FOR DISEASE CONTROL AND PREVENTION

The Division of Cancer Prevention and Control provides funding to the Hawaii Department of Health, through a cooperative agreement, to provide breast and cervical cancer screening and diagnostic services to underserved women, including Native Hawaiian women. The Division of Cancer Prevention and Control also provides funding to the Hawaii Department of Health for the Comprehensive Cancer Control Program. Hawaii has a comprehensive cancer control plan that was developed by a coalition that includes a diverse group of stakeholders. Coalition members include representatives of organizations, such as Papa Ola Lokahi, that focus on the needs of the Native Hawaiian population.

OFFICE ON WOMEN'S HEALTH (OWH)

Advancing System Improvements to Support Targets for Healthy People 2010 (ASIST2010) is a 3-year cooperative agreement program funded by the Office on Women's Health. ASIST2010 uses a public health systems approach to improve performance on objectives that target women and/or men in the following focus areas: cancer, diabetes, heart disease, stroke, access to quality health services, educational and community-based programs, nutrition and overweight physical activity, and fitness. Two of the 12 funded ASIST2010 programs targeting diabetes include as their target population Pacific Islanders:

- National Kidney Foundation of Michigan (Ann Arbor, Michigan).*—The site utilizes PATH, Tomando Control de su Salud and Enhance Fitness programs to provide people with chronic diseases and those at-risk with the skills and tools needed to improve their health outcomes and manage their symptoms. To assure that the programs are culturally appropriate, leaders and programs are gender-specific as needed to reach certain racial and ethnic minority populations, including African Americans, Hispanic/Latinos, Asian Americans/Pacific Islanders, Native Americans, and Arab Americans.
- Wise Woman Program of Saipan, Commonwealth of the Northern Mariana Islands.*—The Wise Woman Village Project (WWVP) of the Northern Marianas Islands Department of Public Health provides outreach, health screening, and education. WWVP addresses noncommunicable diseases (diabetes, mellitus, hypertension, cardiovascular disease, and cervical cancer) in addition to tobacco use assessment and cessation referral. It addresses physical activity promotion through a partnership with a faith-based organization and other community organizations.
- BodyWorks.*—Another OWH program, BodyWorks, is designed to help parents and caregivers of adolescents improve family eating and activity habits. The program focuses on parents as role models and provides them with hands-on tools to make small, specific behavior changes to prevent obesity and help maintain a healthy weight. The program uses a train-the-trainer model to distribute the Toolkit through community-based organizations, State health agencies, nonprofit organizations, health clinics, hospitals and healthcare systems. There are approximately 20 trainers in Hawaii; a list can be found at: <http://www.womenshealth.gov/BodyWorks/find.trainers.statedetail.cfm?state=HI>.

ADMINISTRATION FOR CHILDREN AND FAMILIES: OFFICE OF HEAD START

The Office of Head Start provides grants to various entities including schools, tribes, and nonprofit and for-profit agencies to provide comprehensive child development services to economically disadvantaged children and family. A major focus of services to enrolled children and their families is towards improving health outcomes through the provision of educational, nutritional, and health services. These primary and secondary prevention services are making a major impact on improving health outcomes for those Native Hawaiian children and families that are currently

served under existing Head Start grants. Hawaii is served under region 9. The most recent statewide data (Source: 2008 OHS Program Report Information) shows that Head Start funds a total of 7 grantees, and 21 percent of the Hawaii State HS/EHS children served are Native Hawaiian or other Pacific Islander ethnicity. This includes 1,588 for Head Start and 377 for Early Head Start.

Head Start's goals include prevention and reduction of childhood overweight and obesity, to reduce the incidence of Type 2 Diabetes Mellitus. Obesity is a major risk factor for the development of Type 2 Diabetes Mellitus. The Office of Head Start is conducting a major initiative to prevent and reduce childhood obesity, through a program titled "I Am Moving, I Am Learning". I Am Moving, I Am Learning introduces multidisciplinary teams from local Head Start programs to the science of obesity prevention, and arms them with state-of-the-art resources and best practices for addressing the growing child obesity epidemic in an intentional and purposeful manner.

Head Start also works to prevent and reduce tobacco smoke exposure. The Family and Child Experiences Survey study shows that 45 percent of Head Start families smoke and 56 percent of Early Head Start families smoke. The Office of Head Start and the Indoor Environments Division of the U.S. Environmental Protection Agency are partnering to improve the overall health of Head Start children. The partnership aims to reduce young children's exposure to secondhand smoke and other asthma triggers. The goal of the partnership is not to get parents to stop smoking. Rather, the purpose of the toolkit is for Head Start staff to use the information as a means to educate parents of the many ways to enhance their children's health.

HHS GRANTS PROVIDED TO ORGANIZATIONS SERVING NATIVE HAWAIIANS

Administration for Children and Families/Administration for Native Americans (ACF/ANA)

Grantee.—Wai'anae Coast Comprehensive Health Center

Project Title.—Strengthening Families and Promoting Healthy Lifestyle

Project Funding.—\$542,064 (includes anticipated continuation awards)

Total ANA Funding.—\$2,014,024

The Wai'anae community is located on the western side of the island of Oahu. Its population grew from 3,000 people in 1950 to 45,000 people today, of which 40 percent are Native Hawaiian and 45 percent are under the age of 25. The Wai'anae coast is an economically distressed community ranked highest on the island for: households receiving financial aid and food stamps; households under the poverty line; and rates of unemployment, infant mortality and teen births. Health issues are a major concern in the community as Native Hawaiians have the highest prevalence of obesity and diabetes in the State. Additionally, an estimated 1,000 homeless residents, most of whom are Native Hawaiian, live on the Wai'anae coast.

The Wai'anae Coast Comprehensive Health Center is a Federal Public Health Service Community Health Center 330(e) grantee that has served the community for the past 32 years. During this time, the Center has developed a unique model of healthcare that addresses individual, family and community needs through a combination of traditional and modern practices.

The Strengthening Families and Promoting Healthy Lifestyle Project developed a healthy culinary training program to promote activities to retain and re-establish traditional foods in the family diet. There were 939 youth involved in this project. Many Native Hawaiian at-risk youth demonstrated improved self-esteem and began integrating the traditional culture into their daily lives. For the youth participants that were overweight, the project health activities provided a comforting and encouraging atmosphere to lose weight. The youth were involved in outreach activities like designing the "KidFit T-Shirt" and creating the Health Center's video public service announcements.

For the involved families, the project promoted bonding through exercise, healthy eating and the revitalization of Kumu Ohana, all of which contribute to healthy lifestyles that can prevent diabetes and cancer among Native Hawaiians. In addition, the project created 15 jobs and leveraged resources were more than \$100,000.

Grantee.—Wai'anae Community Re-Development Corporation

Project Title.—The Center for Organic Agriculture and Sustainability

Project Funding.—\$1,152,476 (includes anticipated continuation awards)

Total ANA Funding.—\$1,790,037

According to the project leaders at Ma'o Organic Farms, Wai'anae youth struggle to achieve their socio-economic goals. The statistics suggest a bleak future for many Native Hawaiian youth with the State's highest rates of teen pregnancy, school suspensions, incidents of substance abuse, and juvenile arrests. In addition, Wai'anae is recognized as the most food insecure region of Hawaii with Native Hawaiians

having the highest rates of preventable disease including diabetes, heart disease and some cancers. Despite these statistics, Wai'anae residents still maintain a rural vision, a willingness to perpetuate our community's "country" values and to offer hope and validation to our 'opio of their personal and cultural identities.

The Center for Organic Agriculture and Sustainability, at Ma'o Organic Farms, will positively impact the well-being of Wai'anae youth by promoting healthy lifestyles and decreasing the incidence of diabetes. The project will engage Native Hawaiian youth in the development of organic agriculture and will provide a foundation for economic opportunities for youth participants.

The 3-year project will provide multi-purpose venue for food production that will increase commercial efforts of organic farms and develop a working base for social enterprise, organic agriculture and sustainability that can be replicated in other communities.

Grantee.—Waipa Foundation

Project Title.—Waipa Community Kitchen and Business Incubator Project

Project Funding.—\$709,260

Total ANA Funding.—\$867,010

This is a 3-year project to provide a fully-equipped and certified commercial kitchen facility that will allow farmers, families, and community members to process crops and grow small businesses. The Waipa Community Kitchen and Business Incubator will promote a healthy, diverse, and sustainable local food economy for the Halele'a-Kilauea communities.

Grantee.—University of Hawaii and Manoa Center (Collaborative Project)

Project Title.—The Hawaii Demonstration to Maintain Independence and Employment Project

Project Funding.—\$1,539,002

The Hawaii Demonstration to Maintain Independence and Employment project is a joint endeavor between the Hawaii State Department of Human Services, the University of Hawaii at Manoa Center on Disability Studies, the Hawaii State Department of Health (DOH), and the Hawaii Business Health Council.

These agencies will engage in a collaborative effort with public and private employers, employee groups, and their healthcare providers in a comprehensive community-based effort to assist individuals who are at high risk of becoming disabled/unemployed as a result of diabetes.

The partnership enlists promising and emerging practices to identify and support persons, ages 18 through 60 years old, with potentially disabling and medically determinable physical impairments as a result of diabetes.

Substance Abuse and Mental Health Services Administration (SAMHSA)

Grantee.—Hawaii Families as Allies—Aiea, HI

Program.—Statewide Family Networks SM057920

Congressional District.—HI-01

Fiscal Year 2008 Funding.—\$70,000

Project Period.—9/30/2007–9/29/2010

The Hawaii Statewide Transformation and Empowerment Project (STEP) will conduct training, technical assistance, and networking activities aimed at substantially increasing the involvement of children and youth with emotional, behavioral or mental disorders and their families in all levels of Hawaii's system of care. Family members will be supported so that they will be able to develop and implement a legislative advocacy action plan. STEP will also involve key child-serving agencies, including those responsible for child welfare and juvenile justice, in an initiative to increase their awareness of and adherence to the CASSP values and principles. Another set of activities will focus on youth leadership development, focusing on developing and implementing a legislative advocacy initiative. HFAA Parent Partners will also provide peer supports and mentoring for youth and families in their home communities throughout Hawaii.

Grantee.—Hawaii State Department of Health—Honolulu, HI

Program.—Child Mental Health Initiative SM057063

Congressional District.—HI-01

Fiscal Year 2008 Funding.—\$1,257,281

Project Period.—9/30/2005–9/29/2011

Project Ho'omohala (meaning in Hawaiian, "evolving toward maturity") will develop a system of care to meet transitional needs of youth with emotional and/or behavioral challenges, ages 15–21 in the Kalihi-Palama community. Culturally and linguistically appropriate services will utilize the transition to independence process. Families and youth will be active partners in the governing structure and evaluation process. The goal of this project is to implement a system of care encompassing the transition to independence process for youth with emotional or behavioral challenges between the ages of 15–21, living in the Kalihi-Palama Community. This goal

will be implemented through the following actions: (1) establish a Youth Community Center; (2) train and assign transition specialists to each youth; (3) develop a comprehensive life-skills program; (4) create a range of supportive services (e.g., vocational, healthcare); and (5) develop peer mentoring services. The applicant is the Hawai'i Department of Health on behalf of the governor. Daily management of the grant will be contracted through the Center on Disability Studies at the University of Hawai'i. The Youth Community Center will be operated by the Susannah Wesley Community Center. Wai Aka will provide the young adult support services; families and youth will guide the development, implementation, and evaluation of this project.

Grantee.—Hawaii State Department of Health—Honolulu, HI

Program.—State Data Infrastructure Grants SM058093

Congressional District.—HI-01

Fiscal Year 2008 Funding.—\$156,000

Project Period.—9/30/2007–9/29/2010

During the project period, AMHD will focus on technical implementation of the URS measures, verification of data quality, and increased distribution of reports to its Purchase of Service Provider network. CAMHD will implement the remaining URS developmental measures, but emphasizes building capacity in the knowledge, skills, and abilities of personnel to define and distribute customized reports and to participate more fully in the DIG network. Upon completion AMHD and CAMHD should report on all URS measures, increase distribution of system information to stakeholders including State council, increase integration of the available information into planning and decision making.

Grantee.—Hawaii State Department of Health—Honolulu, HI

Program.—Mental Health Transformation State Incentive Grants SM057457

Congressional District.—HI-01

Fiscal Year 2008 Funding.—\$2,190,500

Project Period.—9/30/2006–9/29/2011

The goal of this mental health systems transformation project is to create a sustainable, fully integrated, comprehensive statewide mental health plan and to implement a system-wide transformation process over the course of a 5-year period. Staffing for this grant can be conceptualized as a model of concentric circles whereby the transformation work group is at the center surrounded by mental health stakeholders coming together in different partnerships to breathe life into the transformation. The next ring supporting these activities is a technical assistance group and project evaluation team comprised of grant-funded staff and in-kind University of Hawaii staff who will assist the transformation work group and stakeholders in tasks such as planning, implementation, program evaluation and workforce development. Finally, the outer ring of the model is the community-at-large whose acceptance of mental health as an integral part of overall well being is required to bring about full transformation of the system. Hawaii, because of its diversity, is in a unique position to develop effective models of service delivery and care that address the needs of the growing multi-cultural population across the country. Hawaii is committed to seizing the opportunity created by national and State strengths and resources; directing and focusing the efforts of all sectors to address priority mental health needs; building on successes to move past an era of Federal court mandates; and realizing the vision of quality mental healthcare across all of Hawaii's communities for the entire population.

Grantee.—United Self-Help—Honolulu, HI

Program.—Statewide Consumer Network SM056346

Congressional District.—HI-01

Fiscal Year 2008 Funding.—\$70,000

Project Period.—9/30/2004–9/29/2010

Bridging Islands will foster and sustain consumer networks within each neighbor island, collaborate with existing networks and strengthen peer mentors. Each goal will address county based needs within each area with specific outcomes. The process will increase State capacity to support effective mental health services while strengthening peer mentors and sustaining neighbor island consumer network development. Collectively, the county and consumers will evaluate lessons learned and incorporate recommendations into the next iteration of transformation activities.

Grantee.—Hawaii State Department of Health—Honolulu, HI

Program.—Youth Suicide Prevention and Early Intervention—Cooperative Agreement State-Sponsored SM058397

Congressional District.—HI-01

Fiscal Year 2008 Funding.—\$500,000

Project Period.—9/30/2008–9/29/2011

The Injury Prevention and Control Section (IPCS) of the DOH is proposing to implement the Hawaii Gatekeeper Training Initiative (HGTI) to reduce completed and attempted suicides among youth ages 10–24. This will be accomplished through training adult gatekeepers in key agencies to recognize and respond to youth who are at risk for suicide. This will also increase youth access to trained gatekeepers in Hawaii. The HGTI will use three training curricula: Applied Suicide Intervention Skills Training (adults), SafeTALK (police officers), and Signs of Suicide (youth). IPCS will leverage the grant resources by incorporating gatekeeper training in three systems that already impact significant numbers of youth in both school and community settings. These agencies and their programs include: Department of Education (Peer Education Program), and School-Based Behavioral Health), the Department of Health Alcohol and Drug Abuse Division (agencies contracted to provide treatment services in their Adolescent Substance Outpatient School-Based Treatment Program), and prevention services in their Youth Substance Prevention Partnerships Initiative), and the Honolulu Police Department (Emergency Psychological Services/Jail Diversion Program). The HGTI will accomplish two goals: (1) enhance State level infrastructure for youth suicide prevention efforts, and (2) enhance youth suicide prevention efforts in three systems: Public School, Alcohol/Substance Abuse Treatment and Prevention, and Law Enforcement.

Center for Substance Abuse Prevention (CSAP)

Grantee.—Parents and Children Together—Honolulu, HI

Program.—Drug Free Communities SP012968

Congressional District.—HI–01

Fiscal Year 2008 Funding.—\$100,000

Project Period.—9/30/2005–9/29/2010

The grantee will: (1) reduce substance abuse among youth and over time, among adults by addressing factors in the community that increase the risk of substance abuse and promote factors to minimize the risk of substance abuse; (2) establish and strengthen citizen participation and collaboration among communities, nonprofit agencies, and Federal, State, local, and tribal governments to support community efforts to deliver effective substance use prevention strategies for youth; (3) use the Strategic Prevention Framework of evidence based prevention strategies to assess needs, build capacity, plan, implement and evaluate community prevention initiatives; and (4) assess and report on the effectiveness of community prevention initiatives to reduce age of onset of any drug use, frequency of use in the past 30 days, increased perception of risk or harm, and increased perception of disapproval of use by peers and adults.

Grantee.—Waipahu Community Association—Waipahu, HI

Program.—Drug Free Communities SP011543

Congressional District.—HI–01

Fiscal Year 2008 Funding.—\$100,000

Project Period.—9/30/2005–9/29/2009

The grantee will: (1) reduce substance abuse among youth and, over time, among adults by addressing the factors in a community that increase the risk of substance abuse and promoting the factors that minimize the risk of substance abuse; and (2) establish and strengthen community anti-drug coalitions.

Grantee.—Coalition For A Drug-Free Hawaii—Honolulu, HI

Program.—Drug Free Communities SP014887

Congressional District.—HI–01

Fiscal Year 2008 Funding.—\$125,000

Project Period.—9/30/2008–9/29/2013

The grantee will: (1) reduce substance abuse among youth and over time, among adults by addressing factors in the community that increase the risk of substance abuse and promote factors to minimize the risk of substance abuse; (2) establish and strengthen citizen participation and collaboration among communities, nonprofit agencies, and Federal, State, local, and tribal governments to support community efforts to deliver effective substance use prevention strategies for youth; (3) use the Strategic Prevention Framework of evidence based prevention strategies to assess needs, build capacity, plan, implement and evaluate community prevention initiatives; and (4) assess and report on the effectiveness of community prevention initiatives to reduce age of onset of any drug use, frequency of use in the past 30 days, increased perception of risk or harm, and increased perception of disapproval of use by peers and adults.

Grantee.—Coalition For A Drug-Free Hawaii—Honolulu, HI

Program.—Sober Truth on Preventing Underage Drinking Act Grants SP015489

Congressional District.—HI–01

Fiscal Year 2008 Funding.—\$50,000

Project Period.—9/30/2008–9/29/2012

The purpose of the Sober Truth on Preventing Underage Drinking (STOP) Act grant program is to prevent and reduce alcohol use among youth in communities throughout the United States. The STOP Act grant program will encourage existing local community coalitions to develop, assess, and implement effective strategies to prevent and reduce underage drinking. Strategies may include: changing local attitudes and norms, and re-evaluating existing laws and policies. (1) Grantee must participate in national evaluation activities of the STOP grant program. (2) STOP Grantees must use the Strategic Prevention Framework (SPF), a five-step evidence based process for community planning and decision-making. The five step process includes: needs assessment, capacity building, planning, implementation and evaluation. (3) STOP grantees must plan and implement a comprehensive approach inclusive of multiple strategies as emphasized in the 2007 Surgeon General's Call to Action to prevent and Reduce Underage Drinking located online at: <http://www.surgeongeneral.gov/topics/underagedrinking/call-to-action.pdf> Emphasis should be given to environmental strategies that incorporate prevention efforts aimed at changing or influencing community conditions, standards, institutions, structures, systems and policies. In addition, grantees must select strategies that lead to long term outcomes. (4) STOP grantees must enhance, not supplant, effective local community initiatives for preventing and reducing alcohol use among youth. For current Drug Free Community grantees, STOP ACT funds can not be used to supplant or replace activities that are presently being supported by Drug Free Community funds, and, separate DFC and STOP ACT accounting systems must be maintained for the purposes of reporting.

Grantee.—Kulia Na Mamo—Honolulu, HI

Program.—HIV/Strategic Prevention Framework SP013382

Congressional District.—HI-01

Fiscal Year 2008 Funding.—\$254,320

Project Period.—9/30/2005–9/29/2010

The project targets Asian and Pacific Islander male-to-female transgender and men who have sex with men, age 27 and older. Many of the former are ex-incarcerated, and both groups, which make up the Mahu (two spirits) community in Hawaii, are minority populations at highest risk for HIV (i.e., of all API diagnosed with AIDS, over 65 percent are MSM, which includes transgender). From our own surveys of over 100 transgender clients, more than 60 percent are ex-inmates, 54 percent are sex industry workers and more than 30 percent are crystal meth users. 50 percent of the participants will be re-entry. Interventions will be provided to approximately 150 participants a year. The project is divided into two parts: (1) *Capacity Building.*—The application will spend the first 6 to 9 months of the first year establishing a workgroup or task force that will conduct a community needs assessment. The task force will be made up of the following agencies: Department of Health STD/AIDS Prevention Branch; Department of Health Disease Control and Outbreak Division; Life Foundation, an AIDS service organization; Drug Addiction Services of Hawaii, Inc.; Coalition for a Drug-Free Hawaii, a prevention agency; Hina Mauka, a treatment/prevention agency; Department of Public Safety; Hawaii Cares—the coalition of Ryan White providers; and other agencies. The needs assessment will be the basis for a strategic plan to be implemented after approval from SAMHSA. During this initial period Kulia Na Mamo will develop memoranda of agreement with treatment agencies, the Department of Public Safety, and others with which to establish linkages to care. Kulia will attend meetings of the HIV Community Planning Group, work with the Jade Ribbon Campaign for hepatitis B testing, and coordinate activities related to hepatitis C with the hepatitis C coordinator at the Department of Health STD/AIDS Prevention Branch. (2) *Implementation, Monitoring, and Evaluation.*—The proposal follows interventions endorsed by the CDC and/or SAMHSA: Prevention.

Grantee.—Hawaii State Office of the Governor—Kaplei, HI

Program.—Strategic Prevention Framework State Incentive Grants SP013944

Congressional District.—HI-01

Fiscal Year 2008 Funding.—\$2,093,000

Project Period.—9/30/2006–9/29/2011

The purpose of Hawaii's SPF State Incentive Grant (SIG) is to improve the quality of life of our citizens by preventing and reducing the abuse and dependence on alcohol and other drugs among people of all ages. The SPF SIG will enable Hawaii to (a) support a coordinated and comprehensive approach to substance abuse prevention; (b) ensure that prevention is the first line of defense against illegal drug use and underage drinking; (c) establish effective alcohol and other substance abuse prevention efforts that are evidence-based, culturally appropriate, and long term; and (d) minimize duplicative efforts among partnering agencies, while promoting coordination and identifying gaps in data and services.

Grantee.—Five Mountains Hawaii—Kamuela, HI

Program.—Drug Free Communities SP012310

Congressional District.—HI-02

Fiscal Year 2008 Funding.—\$125,000

Project Period.—9/30/2005–9/29/2013

The grantee will: (1) reduce substance abuse among youth and, over time, among adults by addressing the factors in a community that increase the risk of substance abuse and promoting the factors that minimize the risk of substance abuse; and (2) establish and strengthen community anti-drug coalitions.

Grantee.—Hamakua Health Center—Honokaa, HI

Program.—CSAP 2008 EARMARKS SP014596

Congressional District.—HI-02

Fiscal Year 2008 Funding.—\$95,305

Project Period.—9/01/2008–8/31/2009

This project is designed to improve access for the low-income and uninsured population and improve the coordination of care between agencies in each of the Health Center service areas, resulting in greater accessibility to support services and increased referral follow-through for patients with risk for and active substance abuse.

Center for Substance Abuse Treatment

Grantee.—Hawaii State Department of Health—Honolulu, HI

Program.—Access to Recovery TI019437

Congressional District.—HI-01

Fiscal Year 2008 Funding.—\$2,750,000

Project Period.—9/30/2007–9/29/2010

The Hawaii Access to Recovery (HI-ATR) program targets the adult population of child welfare families for the Hawaii Island of Oahu (City and County of Honolulu). “Ice” is the major factor behind Hawaii’s explosion of child protection cases, in which Native Hawaiians represent more than 50 percent of Child Protective Services cases and other Asian-Pacific Islanders are also overrepresented. Hawaii is a unique State with (1) the greatest proportions of methamphetamine or “ice” abuse in the Nation, (2) inadequate and fragmented treatment resources and significantly limited recovery support services. HI-ATR Project will introduce a system of vouchers managed electronically through a 42 CFR, Part 2 and HIPAA-compliant web-based information technology (IT) system to improve access to treatment and, subsequent to adequate assessment and referral to an appropriate level of care, genuine independent client choice of service providers, including faith and community-based organizations (FCBOs), especially those that have not previously received public funding. This project will not only provide the critically needed additional capacity to address Hawaii’s ice epidemic but will also contribute significantly to strengthening existing families and healing and reunifying shattered Asian/Pacific Island families, thus ensuring the preservation of the unique heritage and traditions of Hawaii’s peoples.

PRACTITIONERS

Question. Given the need to create practice incentives for practitioners that are aligned with the health reform legislation being proposed (such as cost-effective practice, adoption of quality measures, and use of practice guidelines), what medical legal protections can be extended to practitioners on a Federal level such that the practice of defensive medicine is eliminated?

Answer. The President has stated that he understands that some doctors feel that they are looking over their shoulders out of fear of lawsuits and often order more tests and treatment to avoid being legally vulnerable. He does not advocate caps on malpractice awards, which could be unfair to people who’ve been wrongfully harmed, but he does think we should explore a range of ideas to put patients first while letting doctors focus on practicing medicine. There have been a number of proposals offered in recent years to reduce lawsuits and promote patient safety, from plans to expand the use of “Sorry Works” systems (early disclosure and apology-based mediation) as then-Senator Obama introduced in 2005, to proposals to encourage broader use of evidence-based guidelines as Senator Wyden and others have supported. There are many ideas out there and the President and I want to work with you.

Question. Given the shortage of rural practitioners across America and the limitations associated with recruitment and retention of practitioners to rural Hawaii, what incentives can be established to encourage rural training of practitioners, including needed specialists?

Answer. Effective health action requires an adequately staffed, highly skilled, diverse and interdisciplinary workforce prepared to address health challenges of the

21st century. In HRSA, the budget expands loan repayment and scholarship programs for physicians, nurses, and dentists who are committed to practicing in medically underserved areas. Additionally, funding will enhance the capacity of nursing schools, increase access to oral healthcare through dental workforce development grants, target minority and low-income students, and place an increased emphasis on ensuring that America's senior population gets the care and treatment it needs.

The administration also provided additional funds for the Indian Health Service (IHS) to cover the rising cost of tuition impacting scholarship and loan repayment programs. These programs help IHS compete with other public and private sector employers and bring needed healthcare professionals to remote, rural reservations. In addition, IHS provides grants to universities to train American Indians and Alaska Natives to return to their communities as healthcare professionals. We believe these programs will help ease the shortage of rural practitioners over time.

QUESTIONS SUBMITTED BY SENATOR PATTY MURRAY

HEALTHCARE WORKFORCE

Question. One area of concern that I believe must be addressed is the shortage of healthcare providers. And as the baby boomers retire, the problem is only going to get worse.

I have had a number of roundtables throughout my home State of Washington on this issue. And I know that what we're seeing in Washington State is similar to what is going on across the country. The shortage of doctors, nurses, and other healthcare providers is one of the most serious workforce challenges our country faces.

And as we are working on healthcare reform, I believe it is important to keep in mind that affordable care will not be possible without access to a healthcare provider. In addition, this workforce shortage is only going to get worse as we move to cover more people.

What do you see as our best tools to address this problem within the regular appropriations process?

Answer. The National Health Service Corps provides a venue to incentivize more primary care providers across the spectrum (including dentistry, nursing, and mental health) to serve in underserved areas. This program can be targeted towards people at the end of their education, to address short-term as well as long-term workforce needs. Expanding nurse faculty loan programs will address a critical bottleneck in the education of new nurses to address the current and looming nursing shortage. Providing additional funds for scholarships and loan repayment programs for students—including those targeted to improve diversity—can also have a dramatic impact on ensuring an effective workforce.

The fiscal year 2010 request includes over \$1 billion supporting a wide range of programs to strengthen and support our Nation's healthcare workforce. These investments will expand loan repayment and scholarship programs for physicians, nurses, and dentists who are committed to practicing in medically underserved areas. Additionally, this funding will enhance the capacity of nursing schools and increase access to oral healthcare through dental workforce development grants.

Question. How do you think we can address this problem within healthcare reform?

Answer. We can and should build on existing workforce programs such as the National Health Service Corps and title VII and title VIII. These programs need to be modernized to better address a changing healthcare environment. We should also encourage innovation in telemedicine, health IT, and other avenues to improve practice environments which will enhance workforce productivity and retention.

HOME VISITING

Question. I am so pleased that President Obama and your agency are focusing on Home Visiting as an effective program to ensure that children and families receive the supports and information they need for healthy development, child abuse prevention, safety, and preparation for education. As you know, I introduced the Education Begins at Home Act with Senators Clinton and Bond earlier this year, which focuses on promoting high-quality, effective home visiting programs that improve the health, development, and school readiness of children ages 0 to 5.

I think it's necessary to highlight a few key components to any effective home visiting program to ensure the best outcomes for children across the country. It is critical that any program is evidence-based, which I know is important you and the President as well. Another important component is providing support not only for

health outcomes, but also well being and school readiness, in a continuum of home visiting care. When all of these outcomes are met, home visiting can reduce the need for special education services, help families raise their monthly earnings, reduce child abuse, prepare children to succeed in pre-K or kindergarten, and assist with stronger birth outcomes, among many other benefits.

Do I have your commitment to work towards a model that provides significant support for the continuum of home visiting programs and models, as long as they are evidence-based, in order to meet the varied needs of young children and their families across the country?

Answer. Yes, the Home Visitation initiative will give priority to models that have been rigorously evaluated and shown to have positive effects on critical outcomes for families and children. Additional funds will support promising programs, such as programs based on models with some research evidence of effectiveness and adaptations of previously evaluated programs.

TITLE X FAMILY PLANNING PROGRAM

Question. In a report released last week by the National Academy of Sciences Institute of Medicine, family planning was described as “one of the most significant public health achievements of the 20th century.” The report goes on to say that family planning has resulted in improvements in health, economic and social well-being.

The Institute’s study also cites that “funding for the title X (Ten) Program has not kept pace with a number of factors including: inflation; increased costs of contraceptives, great numbers of people seeking services; or rising insurance costs.”

Do you agree with the assessment that family planning funding has not kept pace with these factors?

Answer. The title X program has been able to maintain access to services for millions of individuals who need family planning services each year through maximizing the resources provided in the appropriations each year. Through the program’s training authority, training has been provided to title X administrators and clinical providers to encourage the most efficient utilization of resources while maintaining quality. In addition, title X providers have been encouraged to use the 340B Drug Pricing Program, cooperative purchasing programs, and other cost-savings mechanisms to cut costs where possible.

Question. Do you think that a significant increase in funding for the title X program will help serve the ever increasing number of American families who are unable to afford the most basic of healthcare services?

Answer. The fiscal year 2010 budget provides an increase that would enable the title X program to serve a greater number of low-income individuals who are currently not receiving services. Currently, 4 in 10 poor women of reproductive age have no insurance coverage, public or private. The Title X Family Planning Program requires that services be provided to all who want and need them, with a priority for services to individuals from low-income families. Title X-funded centers are an important source of preventive healthcare to nearly 5 million women each year, more than 90 percent of whom have family incomes at or below 200 percent of the Federal poverty level. At least 64 percent of those served by title X centers have no insurance coverage for primary healthcare, public or private. According to the most recent National Survey of Family Growth data, a majority of women who obtain care at a family planning center consider it their usual or primary source of healthcare. It is estimated that only 54 percent of women in need of publicly subsidized contraception received those services in 2006, with title X providing services to half (27 percent) of these women.

In addition to the contraceptive services provided under the title X program, title X-funded family planning centers provide a number of related preventive health services that millions of poor and uninsured individuals would likely not otherwise receive. For instance, in 2007, title X-funded health centers provided almost 2.5 million Pap tests; 2.4 million breast exams; 5.4 million tests for sexual transmitted diseases that if left untreated, may lead to infertility; and, 764,126 confidential HIV tests. In addition, it is estimated that nearly 970,000 unintended pregnancies were averted through the services provided by title X-funded centers in 2007.

U.S. DOMESTIC REFUGEE PROGRAM AND THE ECONOMIC CRISIS

Question. Historically, the United States has been the world leader in providing protection and assistance to refugees both internationally through humanitarian assistance and domestically by resettling refugees to the United States. Unfortunately, the resettlement program now finds itself on the brink of crisis.

The Office of Refugee Resettlement (ORR) within the Department of Health and Human Services was established in 1980 to assist refugees admitted by the United

States in obtaining economic self-sufficiency. Since then, ORR's mission has grown to include assisting numerous other vulnerable populations in the United States, among them trafficking victims, torture victims, Cuban/Haitian Entrants, Indo-Chinese Parolees, Iraqi and Afghan Special Immigrants, and unaccompanied alien children. Unfortunately, ORR's budget has not kept up with its growing mission, the changing characteristics of the populations it now serves, and the costs and needs of resettling today's refugees. Coupled with chronic under funding, the challenges connected to the current economic crisis have placed the resettlement program in peril.

Even before the current economic recession, resettlement agencies have been struggling to meet the needs of refugees, and a number of agencies had to close down offices across United States. Now refugees are commonly experiencing great difficulty finding work and paying rent and other basic household needs. Agencies that have relied on private funding, donations and the help of our communities to overcome the insufficient funding are struggling to secure resources in the current environment. The situation is critical; the resettlement program needs immediate reform in key areas to maintain the success it has achieved in the past and to match our international commitment to provide protection to refugees.

How is ORR planning to respond to the consequences of the economic crisis on the resettlement program and ensure adequate assistance to refugees and other vulnerable populations while they work toward integration and self-sufficiency? What steps will ORR take in the future to better respond to emergency situations?

Answer. ORR provides a host of supports to refugees to assist them with achieving economic self-sufficiency and integration, including cash and medical assistance, case management, and employment services. The current economic conditions have made it more difficult for refugees to gain employment quickly, even for those in the Matching Grant program, which historically has been the most successful method for placing refugees into employment quickly. As a result, refugees and other eligible populations are accessing cash and medical assistance for longer periods of time, often for the full 8 months for which they are currently eligible. The number of refugees also is on the rise, and, for the first time since 2001, the number of arrivals appears to be approaching the refugee ceiling set by the State Department. For these reasons, the fiscal year 2010 budget request includes \$337 million for refugee transitional and medical services, \$55 million more than the amount appropriated in fiscal year 2009. ORR will closely monitor arrivals and benefit access, and provide updated cost estimates to Congress as necessary. The Administration is also keenly interested in examining ways to improve refugee resettlement programs, especially in light of the current economic crisis.

EMERGENCY HOUSING ASSISTANCE

Question. The economic crisis is negatively impacting refugees across the country, challenging their successful integration into our communities and making homelessness a real threat to many refugee families. Due to rising living costs and a shortage of jobs, newly arriving refugees are finding it increasingly difficult to secure and maintain employment and housing. As a result, some refugee families are not able to find jobs and meet the cost of rent, and are thus facing eviction and homelessness. Several recent news stories illustrate the challenges refugees are facing with housing and homelessness across the country.

A number of federally funded programs administered by local refugee resettlement agencies assist refugees in securing employment and housing. These programs have been highly effective in helping refugees achieve early self-sufficiency through employment. However, refugees are only eligible for benefits and services for a maximum of the first 8 months in the United States. In the current economic climate it can take refugees longer than 8 months to secure employment which would enable them to afford basic housing. Additionally, many of those refugees who have been able to secure employment have been recently laid off and have lost their source of income. In most of these cases refugees have not worked long enough to qualify for unemployment benefits.

What steps will you take to address the housing needs of resettled refugees and other vulnerable populations served by the ORR to prevent evictions and homelessness for these populations?

Answer. The President's budget request is intended to address many refugee needs. With respect to risk of homelessness, refugees can access a variety of homelessness prevention and assistance programs through the U.S. Department of Housing and Urban Development (HUD) or State or county housing programs. HHS Refugee Resettlement funds have not been targeted to homeless services, beyond the provision of cash assistance and some limited use of social services funds.

Question. How are you planning to address the housing needs of refugees that have been in the United States for more than 8 months, are not longer receiving cash assistance and have not achieve self-sufficiency?

Answer. The President's budget request is intended to address many refugee needs. With respect to risk of homelessness, refugees can access a variety of homelessness prevention and assistance programs through the U.S. Department of Housing and Urban Development or State or county housing programs. HHS Refugee Resettlement funds have not been targeted to homeless services, beyond the provision of cash assistance and some limited use of social services funds.

Question. The cash assistance refugees receive is determined by welfare rates in the States they reside in. In almost all cases (some states would be nice), the level of assistance is below poverty line and does not even cover rent. How will you ensure that refugees are not resettled into an immediate crisis situation, critically dependent on securing a job in order to stay in their homes?

Answer. Refugee populations are exempted from any bars restricting legal permanent resident aliens from accessing public benefits such as TANF, Medicaid, and SSI, and may therefore access a number of services apart from cash assistance provided by ORR, if they are otherwise eligible. In addition, refugees may access services provided through ORR's Refugee Social Services and Targeted Assistance funds, including adjustment services, English language instruction, interpretation and translation services, day care for children, citizenship and naturalization services, etc. The goal of these services is to maximize refugees' prospects for self-sufficiency.

Question. Looking forward to the future, how ORR will ensure that refugees and other vulnerable people it serves have a safety net strong enough to prevent them from losing their homes while they look to secure employment?

Answer. Refugees can access a variety of homelessness prevention and assistance programs through HUD or State and county housing programs. They are also generally eligible for public benefits such as TANF, Medicaid, and SSI. ORR's mandate is to provide services such as cash assistance, medical assistance, case management, and employment services. The goal of these services is to maximize refugees' prospects for self-sufficiency, which will hopefully mitigate any risk of acute problems such as homelessness.

ASSISTING REFUGEES TO ACHIEVE SELF-SUFFICIENCY

Question. The resettlement program has as a main objective to assist refugees to obtain self sufficiency in a short period of time. The economic crisis has made it more difficult for refugees to achieve this goal. While most refugees have typically found employment quickly, the worsening economy has made this process lengthier and more difficult.

The current job market makes programs that provide employment services all the more critical. One of these programs is the Voluntary Agency Matching Grant program. This program enables refugees and other eligible persons to become self-sufficient within 4 to 6 months from the date of their arrival in the United States without resorting to Federal and State welfare programs. The program leverages public funds with private donations at a 2:1 ratio, requiring private voluntary agencies to provide one dollar of private, nongovernmental resources for every \$2 that the Federal Government contributes. Nearly 80 percent of participants in fiscal year 2008 achieved self-sufficiency. Even though the outcomes have been impacted by the current economic crisis, Matching Grant continues to be the most successful program helping to place refugees in jobs in a 4- to 6-month period.

Currently the program serves approximately 27,000 individuals, the same number of individuals that were served by the program in fiscal year 2000. This equals roughly 30 percent of those who could benefit from the program. The program has also been expanded to serve not only refugees, asylees, Cuban/Haitian entrants, but also Iraqi and Afghan Special Immigrant Visas (SIVs) holders and victims of trafficking. The Iraqis arriving as refugees or SIVs are in most cases highly educated and experienced and would therefore be most appropriately served through the Matching Grant (MG) program. Without increased ORR resources, additional places in the MG program will not be available.

As the expression of the public-private partnership the Voluntary Match Grant Program is most successful program helping refugees find jobs. Are you planning to expand the program by providing more resources allowing access for more refugees and other vulnerable populations?

Answer. Under the fiscal year 2010 budget request, the Matching Grant program will be funded at the same level as fiscal year 2009.

Question. Many Iraqis who arrived as SIVs or refugees are highly educated and are facing challenges to achieve self-sufficiency and to find suitable jobs. In the past

the MG program provided better served populations with those characteristics. What role do you envision for the MG program for highly educated refugees, such as the case of Iraqis?

Answer. The Matching Grant program is indeed ideally suited for refugees with good employment prospects, and Iraqi SIVs and refugees are generally excellent candidates. To the extent that funded enrollment slots are available in the area of resettlement, highly educated refugees or SIVs may elect to enroll in the Matching Grant Program.

Question. Highly educated refugees often have to accept the first job available to be able to pay for their basic needs. Such a job may not be inappropriate for their skill level, which leads to frustration on their part and a waste of talent and potential for the American society. Do you plan to initiate and fund any programs that would help highly educated refugees with years of professional experience secure a job appropriate for their skills?

Answer. While there are no special programs that target skilled refugees and no plans to create any expanded assistance to refugee professionals, ORR does have an existing grant with a technical assistance provider looking at professional recertification issues. Most activities for skilled professionals are provided at the discretion of local refugee social services providers as part of their broader employment services assessment and activities related to each Individual Employment Plan. ORR has been working with the Department of Labor to identify resources available to refugee professionals through the Employment and Training Administration's One Stop Centers.

Question. The structure of the U.S. resettlement program and its emphasis on self-sufficiency is often too rigid to account for additional challenges faced by many more vulnerable resettled refugees. Many, for example, have been recently widowed or disabled and will be much less likely to find employment within the program's limited time frame. What changes can be made to account for the special circumstances of certain vulnerable refugees to ensure that they are able to achieve self-sufficiency in safety and dignity?

Answer. ORR has no special programs for individuals with disabilities or other needs, but ORR providers have broad flexibility to work with disabled refugees, and ORR funds may be used to pay for these individuals' medical and mental health costs if individuals are not eligible for Medicaid. ORR providers also make referrals to (SSI) and other benefits and services for refugees who meet disability definitions in title XVI of the Social Security Act. Disabled refugees who are awaiting adjudication of SSI applications may receive Refugee Cash Assistance for up to 8 months while their applications are processed. Finally, ORR is taking further steps to improve the self-sufficiency prospects of disabled refugees, including early discussions with the HHS Office on Disability regarding employment for disabled refugees.

QUESTIONS SUBMITTED BY SENATOR JACK REED

LOW INCOME HOME ENERGY ASSISTANCE PROGRAM

Question. As you know, the Low Income Home Energy Assistance Program (LIHEAP) was funded at \$5.1 billion for the first time in fiscal year 2009, providing much needed assistance to millions of Americans at a time of economic uncertainty. Although some energy costs have temporarily stabilized, the economic standing of millions of Americans has worsened. Like funding for food stamps and unemployment insurance, LIHEAP provides a significant multiplier effect that is important in helping to bring us out of this recession.

While the President's budget request of \$3.2 billion is greater than any request made to Congress in the past, it is still far below last year's appropriation. The National Energy Assistance Directors' Association found that a reduction in LIHEAP funding to \$3.2 billion could result in more than 1.5 million households being dropped from the program, and the average grant for families left in the program being cut by \$70. While I appreciate the fact that this Administration has proposed creating a mandatory contingency fund for LIHEAP when prices spike, that funding is dependent on price volatility and will produce on \$450 million in funding on average per year. We need to have robust funding in the base program.

As you know, the congressional budget resolution matches the President's request of \$3.2 billion for LIHEAP for fiscal year 2010, but would also accommodate an extra \$1.9 billion through a discretionary cap adjustment that maintain funding at the \$5.1 billion level. Would you support LIHEAP funding at the \$5.1 billion allowed under the budget resolution? Will you also work to fully fund this program in future budgets?

Answer. Energy prices are volatile making it difficult to match funding to need. Fiscal year 2009 LIHEAP funding (\$5.1 billion) was provided when energy prices were at their peak (oil at \$124 per barrel in the second quarter of 2008). Oil prices subsequently declined significantly as did Energy Department estimates of average home heating costs. The administration proposed the mandatory trigger mechanism to address volatility in energy prices. Under this proposal, mandatory funding would be provided in response to quarterly energy price increases. If oil and gas prices in the fourth quarter of 2009 exceed peak 2008 prices by just 1.8 percent, total LIHEAP funding of \$5.1 billion would be provided in fiscal year 2010 through a combination of the trigger (\$1.9 billion) and the discretionary budget request (\$3.2 billion).

IMMUNIZATIONS

Question. Immunizing our country's children—and adults—has been a priority for me throughout my tenure in Congress. I was particularly pleased that the Economic Recovery Act contained an additional \$300 million over the next 2 years for immunizations for the uninsured and underinsured. But, once that funding runs out, the baseline funding that the President proposed would likely fall back to \$500 million. As you may know, I have been joined by 17 of my colleagues in supporting more than \$800 million in baseline funding to immunize this population. Have you given any thought to how you will fill the financial void after next year should funding fall back to \$500 million?

Answer. Historically, vaccines are one of the most successful and cost effective public health tools for preventing serious disease and death. The Center for Disease Control and Prevention's (CDC) immunization investments save lives and dollars by providing individuals and communities with a strong level of protection from vaccine-preventable diseases. The Recovery Act 317 section funding provided a historic opportunity to leverage section 317 immunization investments by augmenting existing public health capacity and federally purchased vaccines.

In accordance with the Recovery Act, CDC is investing these funds in one-time efforts that will have the most health impact. The Recovery Act funding CDC received is being used to make vaccines available to more children, adolescents, and adults; help health departments learn how to improve their access to insurance reimbursement; increase awareness and provider education about immunization; and strengthen the evidence base for immunization policies and programs. These investments will have long-term benefits beyond the life of the funding by increasing the number of people vaccinated, providing immunization tools and resources for parents and healthcare providers, and assessing the impact of recently recommended vaccines to inform national vaccine policy.

PANDEMIC PREPAREDNESS

Question. According to testimony before this panel on April 30, I understand that States have purchased only 23 million of the 31 million courses of antiviral treatments called for under the National Strategy on Pandemic Influenza. Rhode Island is only equipped with 10.5 percent of its allocation. Given the potentially urgent need for these medications, how does the Department of Health and Human Services plan to address the shortfall in State stockpiling efforts and prevent illness?

Answer. Currently, State stockpiles have 24.5 million treatment courses. The Department is considering extending the Federal subsidy program for State antiviral stockpiling beyond the current end date of September 1, 2009, to allow States the ability to purchase up to an additional 4 million treatment courses during the fall and upcoming flu season necessitated by the current swine flu pandemic. States have already received 11 million treatment courses collectively from the Federal influenza antiviral drug stockpile in early May 2009 as a response measure for the H1N1 virus outbreaks in the United States. These treatment courses pushed out to States from the Federal stockpile have now been added to each respective State stockpile total. For example, to use the case of Rhode Island, the Federal push of 25 percent of their pro rata Federal allotment now added to their State stockpile (representing about 40,000 treatment courses) brings the new total to about 52,000 treatment courses. Therefore, Rhode Island is now equipped with about 46 percent of its State stockpile program pro rata allocation. Furthermore, the 11 million treatment courses in total pushed out from the Federal stockpile will also be replenished in full and that process is now underway. In addition, the Federal stockpile, which will be replenished to the initial 44 million treatment course level, will again be available in full for distribution to States should the need arise.

HEALTHCARE WORKFORCE

Question. The Senate and the House are poised to have a meaningful debate on healthcare reform. With reform, we must also ensure that there is a workforce to adequately address the expected increase in patients. I am aware that the Economic Recovery Act contained an additional \$200 million for title VII health professions programs. However, I am concerned that even with this increase, the funding level in the budget would not adequately address workforce shortages for years to come—especially in light of reform. In light of this, nearly half of my colleagues in the Senate have joined me in supporting \$330 million for title VII health professions programs. How did the administration account for the potential effects of healthcare reform in budgeting for an adequate primary care workforce?

Answer. We are aware that with the expansion of coverage comes the need to provide primary care and other health services, particularly in areas that are currently underserved. Investments through the Recovery Act will assist in expanding and improving the efficiency of our provider workforce. We look forward to working with Congress to address the workforce needs that will arise from comprehensive health reform.

CONQUER CHILDHOOD CANCER ACT

Question. Last year, Congress passed and President Bush signed the Caroline Pryce Walker Childhood Cancer Act. Among other provisions, this law requires CDC to collect information on the causes, treatments, and effects of childhood cancer within weeks of learning of this information in a comprehensive childhood cancer registry. Individualized and aggregate data would dramatically enhance research initiatives and open the door for new, successful treatment options for patients. The CDC Cancer Registry line has been flat funded for years. Given the administration's effort to spur health innovation and research, how will you capitalize on these tangential, but important, research, and treatment tools?

Answer. CDC collects and maintains individual level data on the diagnosis and treatment of childhood cancer cases in 45 States and the District of Columbia. The National Cancer Institute (NCI) collects similar data in the remaining 5 States and these data are combined to describe the incidence of cancer in the United States. Each year data are collected on approximately 12,000 to 13,000 cancer cases among children younger than 20 years of age. Data are collected on demographics, place of residence, type of cancer and stage at diagnosis, as well as first course of treatment. To fully understand the requirements for and feasibility of conducting national rapid case ascertainment for childhood cancers, CDC will host a meeting in the fall of 2009 which will include experts in childhood cancer research and cancer surveillance as well as critical partners such as the NCI and the American Cancer Society. One of the goals of this meeting will be to lay out all possible approaches that could be taken to address the data needs for childhood cancer research. In addition, optimal designs of a rapid-case ascertainment system will be described and explored for future planning.

CDC supports and encourages research utilizing cancer registry data. For example, CDC provides data annually to the Central Brain Tumor Registry of the United States which conducts research and provides detailed data on benign and malignant brain tumors among children. In addition, CDC utilizes cancer registry data to report incidence and geographic variation of childhood cancer. CDC encourages and provides leadership in the use of State and national data for research into treatment and survival among children diagnosed with cancer and will establish collaborative relationships with the pediatric cancer community that are needed to promote this research. Working with State central cancer registries, CDC promotes the use of registry data for research purposes within the States and the District of Columbia. CDC is active in developing electronic reporting systems for cancer surveillance data which holds great promise in improving the timeliness of data.

QUESTIONS SUBMITTED BY SENATOR THAD COCHRAN

Question. In your May 6 testimony on Health Reform in the 21st Century before the House Committee on Ways and Means, you noted the need for investments in prevention and wellness. In allocating those investments, will you devote any additional resources to the prevention of osteoporosis, a disease that 10 million Americans have and 34 million are at risk for, and that costs our healthcare system an estimated \$19 billion per year?

Answer. The Recovery Act included \$1 billion for prevention and wellness programs including \$650 million for a prevention and wellness initiative. Details re-

garding this initiative will be announced this summer. Our health reform efforts will build on this initial investment in health reform by supporting proposals that improve access to appropriate clinical prevention services such as osteoporosis screening in postmenopausal women and community-based prevention interventions that target the main causes of chronic disease.

Question. In addition to a renewed focus on prevention, many of the health reform proposals under consideration include programs for chronic disease management. Given that 10 million Americans have osteoporosis and another 2 million Americans suffer from other rare diseases of the bone like Paget's disease of the bone and osteogenesis imperfecta, will you include these bone diseases as part of such disease management programs?

Answer. Yes. Osteoporosis is a classic example of a disease susceptible to chronic disease management. Models of chronic disease management apply to any disease that requires ongoing medical management and monitoring and will not be applied on a restrictive basis only to named diseases. This is why we feel it is important to avoid listing specific diseases for coverage—it implies that anything not listed is excluded. We take an entirely inclusive approach. The goal is to improve people's health.

QUESTIONS SUBMITTED BY SENATOR JUDD GREGG

REFUGEE RESETTLEMENT PROGRAM

Question. As you know, the main objective of the refugee resettlement program is to assist refugees so they become self-sufficient in the shortest period of time. Unfortunately, the economic crisis has made it more difficult for refugees to achieve this goal, making programs that provide employment services all the more critical, especially the Voluntary Agency Matching Grant program, which enables refugees and other eligible persons to become self-sufficient within 4 to 6 months from the date of arrival in the United States without resorting to Federal and State welfare programs. Leveraging public funds with private donations at a 2:1 ratio, the program currently serves approximately 27,000 individuals and is arguably the most successful job placement program for refugees with 80 percent of fiscal year 2008 participants achieving self-sufficiency. Given the overall objective of the refugee resettlement program, do you believe enough resources are being allocated to the Voluntary Agency Matching Grant program to maximize utility?

Answer. The current economic conditions have made it more difficult for refugees to gain employment quickly, even for those in the Matching Grant program, which historically has been the most successful method for placing refugees into employment quickly. As a result, refugees and other eligible populations are accessing cash and medical assistance for longer periods of time, often for the full 8 months for which they are currently eligible. The number of refugees also is on the rise, and, for the first time since 2001, the number of arrivals appears to be approaching the refugee ceiling set by the State Department. Office of Refugee Resettlement will closely monitor arrivals and benefit access, and provide updated cost estimates to Congress as necessary, including resources provided to the Matching Grant program.

Question. Recently, the administration requested additional funds to support efforts to combat H1N1 influenza, including the authority to use Project BioShield Special Reserve Funds (SRF) to fund the development and/or procurement of an H1N1 influenza vaccine. As you know, Congress created the Project BioShield SRF to procure medical countermeasures against chemical, biological, radiological, and nuclear (CBRN) threats and appropriated \$5.6 billion to remain available until 2013. A transfer of funds from the Project BioShield SRF could have a devastating impact on efforts to develop countermeasures for CBRN threats and call into question the Government's commitment to procure such products, which could force companies to scale back, or abandon, efforts to produce biosecurity products. Recognizing the importance of pandemic influenza preparedness, how does the Department intend to balance these two critical priorities in the near-term? What do you believe is the appropriate funding level for the SRF to adequately support near-term CBRN acquisitions and provide confidence to the biodefense industry?

Answer. The Biomedical Advanced Research and Development Authority (BARDA) within the Department of Health and Human Services (HHS) Office of the Assistant Secretary for Preparedness and Response develops and procures medical countermeasures for CBRN threats, pandemic influenza, and emerging infectious diseases. BARDA programs are funded through the SRF (CBRN countermeasure procurement), pandemic influenza funding (including for advanced development and

procurement), and annual appropriations for advanced research and development (CBRN countermeasures). HHS' intent is to continue to utilize the SRF and annual advanced development appropriations for their intended uses (i.e., the procurement and development of CBRN countermeasures, respectively).

Project BioShield was funded through the Department of Homeland Security (DHS) Appropriations Act of 2004 (Public Law 108-90) which established the SRF by advance-appropriating \$5.6 billion for the procurement of countermeasures against CBRN agents from fiscal year 2004 to fiscal year 2013. The act allows the HHS Secretary, with concurrence from the DHS Secretary and approval from the Director of OMB, to develop and procure products that are within 8 years of FDA approval. DHS has issued Material Threat Determinations and Population Threat Assessments for 13 CBRN agents, upon which the BARDA Implementation Plan is based. To date BARDA has obligated \$2 billion of the Special Reserve Fund on 5 CBRN programs that have delivered anthrax vaccines and therapeutics, botulinum antitoxins, and radiological drugs to the Strategic National Stockpile. In fiscal year 2009, Congress transferred \$412 million from the SRF to support CBRN advanced development and pandemic influenza. The fiscal year 2010 President's budget proposes transferring \$305 million from the SRF for CBRN Advanced Development. The long-term success of Project BioShield is directly tied to the success of the Advanced Development program. Over the next 4 years, BARDA will obligate the remaining \$2.9 billion in the SRF by expanding its portfolio of late-stage products in anthrax vaccines, smallpox antivirals, chemical agent antidotes, and other radiological drugs in order to develop next-generation products.

QUESTION SUBMITTED BY SENATOR KAY BAILEY HUTCHISON

MEDICAL COUNTERMEASURES

Question. In addition to the recently circulating H1N1 and H5N1 influenza strains, there is a host of emerging infectious diseases and biothreat agents for which we need to develop medical countermeasures in order to protect the health of the American people. In light of the broad range of possible biothreats, as well as the long lag time and high costs associated with developing drugs, how does HHS plan to transition R&D into these lifesaving countermeasures in quantities large enough to cover our population? And how does HHS plan to disseminate them rapidly enough to be able to make a difference in the event of an outbreak or attack?

Answer. HHS has implemented the Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) to manage the development and deployment of CBRN countermeasures, from the basic research phase at NIH to procurement through Project BioShield. The PHEMCE is a coordinated, inter-agency effort led by the HHS Assistant Secretary for Preparedness and Response and includes the Centers for Disease Control and Prevention, Food and Drug Administration, and the National Institutes of Health (NIH). Ex officio members include the Department of Homeland Security, Department of Veterans Affairs, and the Department of Defense. The PHEMCE defines and prioritizes CBRN medical countermeasure (MCM) requirements, integrates and coordinates research, development, procurement, and deployment and use strategies for MCMs. The investment in biodefense research and development has led to fundamental discoveries and has laid the foundation for promising drugs and vaccines for biodefense purposes. To date, two programs started at NIH have reached the level of maturity required for consideration into a late-stage development program funded under Project BioShield (i.e., product is within 8 years of FDA approval). Once products are procured through Project BioShield, they are placed in the Strategic National Stockpile (SNS). The SNS works with State and local partners to ensure that medical countermeasures can be distributed as quickly as possible during a public health emergency.

CONCLUSION OF HEARINGS

Senator HARKIN. The subcommittee will stand recessed.

[Whereupon, at 3:32 p.m., Tuesday, June 9, the the hearings were concluded, and the subcommittee was recessed, to reconvene subject to the call of the Chair.]